ARKANSAS STATE POLICE HEALTH BENEFIT PLAN
LITTLE ROCK AR

Health Booklet

BENEFITS ADMINISTERED BY

A UnitedHealthcare Company

Amendment
Effective January 1, 2011
ARKANSAS STATE POLICE HEALTH BENEFIT PLAN

The Health Benefit Summary Plan Description is hereby amended as follows:

1. The following portion(s) of the INTRODUCTION is hereby added:

The Plan Administrator believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Questions regarding which protection apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at:

ARKANSAS STATE POLICE HEALTH BENEFIT PLAN
1 STATE POLICE PLZ
LITTLE ROCK AR 72209.
501-618-8701

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

2. The End of Plan's Fiscal Year portion of the PLAN INFORMATION is hereby deleted:

Name, Title, And Address Of The Principal Place Of Business Of Each Trustee Of The Plan (If The Plan Has A Trust)	DIRECTOR OF ARKANSAS STATE POLICE 1 STATE POLICE PLZ LITTLE ROCK AR 72209 ASSISTANT DIRECTOR OF ARKANSAS STATE POLICE 1 STATE POLICE PLZ LITTLE ROCK AR 72209 COMMANDER OF ADMINISTRATIVE SERVICES DIVISION FOR ARKANSAS STATE POLICE 1 STATE POLICE PLZ LITTLE ROCK AR 72209 ARKANSAS STATE POLICE 1 STATE POLICE PLZ LITTLE ROCK AR 72209

3. The following portion(s) of the PLAN INFORMATION is hereby revised:

Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.

4. The following portion(s) of the SCHEDULE OF BENEFITS, Benefit Plan 001 is hereby deleted:

	IN-NETWORK	OUT-OF-NETWORK
Individual Lifetime Maximum Benefit Excluding Prescription Benefits	$5,000,000	

5. The following portion(s) of the SCHEDULE OF BENEFITS, Benefit Plan 001 are hereby revised:

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		
Urgent Care:		
• Paid By Plan After Deductible	80%	60%
Emergency Room / Emergency Physicians:		
• Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services:		
Physician Services (General Practitioner, Family Practice, Internal Medicine, Physician Assistant And Pediatrician):		
• Co-pay Per Visit	$30	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Charges For A Radiologist, Anesthesiologist Or Pathologist While In The Physician's Office:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Specialist Services:		
• Paid By Plan After Deductible	80%	60%
Charges For A Radiologist, Anesthesiologist Or Pathologist While In The Specialist's Office:		
• Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		No Benefit
Preventive / Routine Physical Exams		
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Screenings / Services At Appropriate Ages:		
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	

6. The following portion(s) of the SCHEDULE OF BENEFITS, Benefit Plan(s) 002, 003, and 004 is hereby deleted:

	TRADITIONAL PLAN
Individual Lifetime Maximum Benefit Excluding Prescription Benefits	$5,000,000

7. The following portion(s) of the SCHEDULE OF BENEFITS, Benefit Plan(s) 002, 003, and 004 are hereby revised:

	TRADITIONAL PLAN
Physician Office Services:	
Physician Services (General Practitioner, Family Practice, Internal Medicine, Physician Assistant And Pediatrician):	
• Co-pay Per Visit	$30
• Paid By Plan	100% (Deductible Waived)
Charges For A Radiologist, Anesthesiologist Or Pathologist While In The Physician's Office:	
• Paid By Plan	100% (Deductible Waived)
Specialist Services:	
• Paid By Plan After Deductible	80%
Charges For A Radiologist, Anesthesiologist Or Pathologist While In The Specialist's Office:	
• Paid By Plan After Deductible	80%

	TRADITIONAL PLAN
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:	
Preventive / Routine Physical Exams At Appropriate Ages:	
• Physician Office Co-pay Per Visit	$30
• Paid By Plan	100% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:	
• Physician Office Co-pay Per Visit	$30
• Paid By Plan	100% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages:	
• Physician Office Co-pay Per Exam	$30
• Paid By Plan	100% (Deductible Waived)

8. The Per Visit Maximums for the following essential health benefit on the SCHEDULE OF BENEFITS are hereby deleted:

Chiropractic

9. The Annual Dollar Maximums for the following essential health benefits on the SCHEDULE OF BENEFITS are hereby deleted:

Ambulance, Private Duty Nursing, Preventative Routine Service, Speech Therapy

10. The INDIVIDUAL LIFETIME MAXIMUM BENEFIT portion(s) of the OUT-OF-POCKET EXPENSES AND MAXIMUMS is hereby deleted.

11. The following portion(s) of the ELIGIBILITY AND ENROLLMENT are hereby revised:

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as a uniformed Employee who regularly works full time 40 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

An **eligible Dependent** includes:

- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents who meet the eligibility criteria listed below:

  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;

- A Dependent does not include the following:

  - A Child who is under the age of 26, who is eligible for group health benefits under their employer or their spouse's employer;

12. The following portion(s) of the ELIGIBILITY AND ENROLLMENT is hereby added:

- A Dependent does not include the following:

  - If both the husband and wife are Employees, they may choose to have one covered as the Employee, and the spouse covered as the Dependent of the Employee, or they may choose to have both covered as Employees. Eligible Children will be enrolled as Dependents of one or both spouses.

13. The ELIGIBILITY REQUIREMENTS - Eligibility Criteria portion(s) of the ELIGIBILITY AND ENROLLMENT is hereby deleted.

14. The following portion(s) of the ELIGIBILITY AND ENROLLMENT is hereby revised:

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

and the Dependent Child fits the following category:

- If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

  - The Dependent must not be able to hold a self-sustaining job due to the disability; and
  - Proof must be submitted as required; and
  - The Employee must still be covered under this Plan.

  A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of Totally Disabled, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Section in this document.

(Applies to Class(es) R01, R02, X01, X02) Employees have the right to choose which eligible Dependents are covered under the Plan.

15. The following portion(s) of the ELIGIBILITY AND ENROLLMENT is hereby added:

DEPENDENT CHILD SPECIAL OPEN ENROLLMENT PERIOD

On the first day of the first plan year beginning on or after September 23, 2010, this Plan will provide a 30-day Dependent Child special open enrollment period for Dependent Children who have not yet reached the limiting age under this Plan. During this Dependent Child special open enrollment period, Employees who are adding a Dependent Child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the Plan Year if the Employer receives the completed enrollment form and the applicable contribution within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

During this special enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered employees will also be able to make a change in coverage for themselves and their eligible Dependents.

16. The following portion(s) of the TERMINATION is hereby deleted:

EMPLOYEE'S COVERAGE (Applies to Class(es) A01, A02, C01, C02)

- The date in which You reach Your individual Lifetime Maximum Benefit under this Plan; or

EMPLOYEE'S COVERAGE (Applies to Class(es) R01, R02, X01, X02)

- The date in which You reach Your individual Lifetime Maximum Benefit under this Plan; or

YOUR DEPENDENT'S COVERAGE

- If Your Dependent Child qualifies for Extended Dependent Coverage as a Full-Time Student, the day of the month in which your Dependent Child no longer qualifies as a Full-Time Student unless the Dependent Child qualifies for a medically necessary leave of absence (see Extended Dependent Coverage section for more information) or the day of the month Your Dependent Child turns 25, whichever is earlier; or

- The date in which the Dependent reaches the individual Lifetime Maximum Benefit under this Plan; or

17. The following portion(s) of the PRE-EXISTING CONDITION PROVISION is hereby added:

Note: Pre-Existing Condition exclusions will not apply to any Covered Person under the age of 19.

18. The following portion(s) of the COBRA CONTINUATION OF COVERAGE is hereby added:

PAYMENT FOR CONTINUATION OF COVERAGE

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him/her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(s) will be termed from the Plan in accordance with the plan language above.

19. The following portion(s) of the MENTAL HEALTH BENEFITS is hereby revised:

PRESCRIPTION DRUGS

The Plan shall cover Prescription drugs as specified on the Schedule of Benefits. Such drugs must be approved by the Food and Drug Administration and must be dispensed by a licensed pharmacist, Physician or dentist. Antigen and allergy vaccine dispense by a Physician or certified laboratory shall be a Covered Expense. Covered Prescription expense shall exclude birth control devices. Norplant implants or similar devices are also excluded. Vitamins, which require a Prescription by law, and are used to treat a specific Illness shall be considered a Covered Expense.

20. The following portion(s) of the MENTAL HEALTH BENEFITS is hereby revised:

COVERED BENEFITS

- The Covered Person must be ill to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.

21. The following portion(s) of the SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY BENEFITS is hereby revised:

COVERED BENEFITS

- The Covered Person must be ill to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.

22. The following portion(s) of the UTILIZATION MANAGEMENT are hereby revised:

Medical Director Oversight. A UMR Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine medical appropriateness using evidence-based clinical criteria.

Other Medical Management Services

Case Management Services are designed to identify catastrophic and complex Illnesses, transplants and trauma cases. UMR Care Management's case management specialists identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified from the Notification review process, national criteria and system flags based on ICD-9 diagnosis, CPT procedure code and potential high dollar claim criteria. UMR Care Management works directly with the patient, family members, treating Physician and facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person can request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine service is a 24/7 health information line that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

23. The following portion(s) of the GENERAL EXCLUSIONS are hereby revised:

Tobacco Addiction: Diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine.

Vitamins, Minerals and Supplements, even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician and meet Clinical Eligibility for Coverage.

Weight Control: Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling.

24. The following portion(s) of the CLAIMS AND APPEAL PROCEDURES are hereby revised:

TYPES OF CLAIMS AND DEFINITIONS

Note that this Plan does not require notification for urgent or Emergency care claims, however Covered Persons may be required to notify the Plan following stabilization. Please refer to the Utilization Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation when a sudden and serious condition such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

25. The following portion(s) of the CLAIMS AND APPEAL PROCEDURES is hereby added:

TIMELINES FOR INITIAL BENEFIT DETERMINATION

- Emergency and/or Urgent Care Claim: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the medical necessity, but not later than 24 hours after the receipt of the claim by the Plan.

26. The following portion(s) of FRAUD is hereby revised:

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that you receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

27. The following portion(s) of FRAUD is hereby added under Covered Person must:

- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

28. The following portion(s) of the PLAN AMENDMENT AND TERMINATION INFORMATION is hereby deleted:

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Customer should reflect the provisions of the Trust Agreement regarding distribution of assets upon termination of the Plan funded under the VEBA Trust:

29. The following portion(s) of the PLAN AMENDMENT AND TERMINATION INFORMATION is hereby revised:

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

The assets of the Arkansas State Policy Health Benefit Plan (Plan) upon termination of Plan shall be distributed to or placed into the successor plan for the benefit of the Covered Person's of the Plan. If no successor plan is established the Plan assets will be distributed pursuant to a resolution adopted by the Arkansas State Police Commission as pursuant to Arkansas Code §12-8-210 (c).

30. The following portion(s) of the GLOSSARY OF TERMS are hereby deleted:

Accredited Institution of Higher Education

Full-Time Student or Student

Lifetime Maximum Benefit

31. The following portion(s) of the GLOSSARY OF TERMS are hereby added:

Essential Health Benefits means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care, etc.).

Non-Essential Health Benefits means any medical benefit that is not an Essential Benefit. Please refer to the Essential Health Benefits definition.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Amendment
Effective January 1, 2010
ARKANSAS STATE POLICE HEALTH BENEFIT PLAN
Implemented in Plan Year 01-01-2010 to 01-01-2011

The Health Benefit Summary Plan Description is hereby amended as follows:

1. The following portion(s) of the SCHEDULE OF BENEFITS, Benefit Plan 001, is hereby deleted from the Summary Plan Description.

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		No Benefit
Immunizations (Flu, Flumist And Administration Of H1N1 Vaccine Only):		
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	

And replaced with:

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
Immunizations (Flumist And Administration Of H1N1 Vaccine Only):		No Benefit
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	
Flu Shots:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

2. The following portion(s) of the SCHEDULE OF BENEFITS, Benefit Plan 001, is hereby added to the Summary Plan Description.

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits For Children Include:		
Immunizations Including Administration of H1N1 Vaccine:		No Benefit
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	
Flu Shots:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

3. The following portion(s) of the SCHEDULE OF BENEFITS, Benefit Plan(s) 002, 003, and 004, is hereby deleted from the Summary Plan Description.

	TRADITIONAL PLAN
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:	
Immunizations (Flu, Flumist And Administration Of H1N1 Vaccine):	
• Physician Office Co-pay Per Visit	$30
• Paid By Plan	100% (Deductible Waived)

And replaced with:

	TRADITIONAL PLAN
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:	
Immunizations (Flumist And Administration Of H1N1 Vaccine):	
• Physician Office Co-pay Per Visit	$30
• Paid By Plan	100% (Deductible Waived)
Flu Shots:	
• Paid by Plan	100% (Deductible Waived)

4. The following portion(s) of the SCHEDULE OF BENEFITS, Benefit Plan(s) 002, 003, and 004, is hereby added to the Summary Plan Description.

	TRADITIONAL PLAN
Preventive / Routine Care Benefits For Children Include:	
Immunizations Including Administration Of H1N1 Vaccine:	
• Physician Office Co-pay Per Exam	$30
• Paid By Plan	100% (Deductible Waived)
Flu Shots:	
• Paid By Plan	100% (Deductible Waived)

Amendment
Effective January 1, 2010
ARKANSAS STATE POLICE
Implemented in Plan Year 01-01-2010 to 01-01-2011

The Health Benefit Summary Plan Description is hereby amended as follows:

The following portion(s) of the COORDINATION OF BENEFITS are hereby deleted from the Summary Plan Description.

MEDICARE

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

And replaced with:

An eligible Employee who is covered under this Plan and who Retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution for Employee and / or Dependent coverage and must purchase Medicare A & B.

Amendment
Effective January 1, 2010
ARKANSAS STATE POLICE
Implemented in Plan Year 01-01-2010 to 01-01-2011

The Health Benefit Summary Plan Description is hereby amended as follows:

1. The following portion(s) of the MEDICAL SCHEDULE OF BENEFITS, BENEFITS PLAN(S) 001 are hereby added to the Summary Plan Description.

	IN-NETWORK	OUT-OF-NETWORK
Supplemental Accident Expense Benefits - Including Dental Injuries:		
• Maximum Benefit Per Accident	$300	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Note: Regular Plan Benefits Will Apply For Any Remaining Expenses.		

	IN-NETWORK	OUT-OF-NETWORK
Oral Surgery Benefits:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

2. The following portion(s) of the MEDICAL SCHEDULE OF BENEFITS, BENEFIT PLAN(S) 002, 003, 004 are hereby added to the Summary Plan Description.

	TRADITIONAL PLAN
Supplemental Accident Expense Benefits – Including Dental Injuries:	
• Maximum Benefit Per Accident	$300
• Paid By Plan	100% (Deductible Waived)
Note: Regular Plan Benefits Will Apply For Any Remaining Expenses.	

	TRADITIONAL PLAN
Oral Surgery Benefits	
Paid By Plan	100% (Deductible Waived)

3. The following underlined portion(s) of the COVERED MEDICAL BENEFITS is hereby added to the Summary Plan Description.

60. **Supplemental Accident Expenses Benefit** as shown on the Schedule of Benefits.

Table of Contents

ARKANSAS STATE POLICE HEALTH BENEFIT PLAN

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as information on a Covered Person's rights and obligations under the ARKANSAS STATE POLICE HEALTH BENEFIT PLAN Health Benefit Plan (the "Plan"). As a valued Employee of ARKANSAS STATE POLICE HEALTH BENEFIT PLAN, we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

ARKANSAS STATE POLICE HEALTH BENEFIT PLAN is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and LDI Integrated Pharmacy Services for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of Covered Benefits through contributions, Deductibles, out-of-pocket, and Plan Participation amounts as described in the Schedule of Benefits.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this Plan.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and is known as a Summary Plan Description ("SPD").

This document becomes effective on January 1, 2010.

PLAN INFORMATION

Plan Name	ARKANSAS STATE POLICE HEALTH BENEFIT PLAN
Name And Address Of Employer	ARKANSAS STATE POLICE HEALTH BENEFIT PLAN 1 STATE POLICE PLZ LITTLE ROCK AR 72209
Name, Address And Phone Number Of Plan Administrator	ARKANSAS STATE POLICE HEALTH BENEFIT PLAN 1 STATE POLICE PLZ LITTLE ROCK AR 72209 501-618-8701
Named Fiduciary	ARKANSAS STATE POLICE HEALTH BENEFIT PLAN
Employer Identification Number Assigned By The IRS	71-0546049
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name, Title, And Address Of The Principal Place Of Business Of Each Trustee Of The Plan (If The Plan Has A Trust)	DIRECTOR OF ARKANSAS STATE POLICE 1 STATE POLICE PLZ LITTLE ROCK AR 72209 ASSISTANT DIRECTOR OF ARKANSAS STATE POLICE 1 STATE POLICE PLZ LITTLE ROCK AR 72209 COMMANDER OF ADMINISTRATIVE SERVICES DIVISION FOR ARKANSAS STATE POLICE 1 STATE POLICE PLZ LITTLE ROCK AR 72209 ARKANSAS STATE POLICE 1 STATE POLICE PLZ LITTLE ROCK AR 72209
Name And Address Of Agent For Service Of Legal Process	ARKANSAS STATE POLICE 1 STATE POLICE PLZ LITTLE ROCK AR 72209 Services of legal process may also be made upon the Plan Administrator.

Funding Of The Plan	Employer Contributions **(Applies to Active Employees and their Dependents)** Employer and Employee Contributions **(Applies to Retired Employees)** Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Plan Year begins on the individual's Effective Date and runs through December 31 of the same Plan Year.
End of Plan's Fiscal Year	June 30
Compliance	It is intended that this Plan meet all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.
Discretionary Authority	The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in its sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001

All health benefits shown on this Schedule of Benefits are subject to the following: Lifetime and annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and Covered Benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Notification may be required before benefits will be considered for payment. Failure to obtain notification may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and notification procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Lifetime Maximum Benefit Excluding Prescription Benefits	$5,000,000	
Annual Deductible Per Calendar Year:		
• Per Person	$500	$1,000
• Per Family	$1,000	$2,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum:		
• Per Person	$2,500	$5,000
• Per Family	$5,000	$10,000
Ambulance Transportation:		
• Maximum Benefit Per Calendar Year	$1,000	
• Paid By Plan	80% (Deductible Waived)	80% (Deductible Waived)
Chiropractic Services:		
• Maximum Visits Per Calendar Year	50 Visits	
• Maximum Benefit Per Visit	$25	$25
• Paid By Plan After Deductible	80%	60%
Durable Medical Equipment:		
• Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment:		
Urgent Care:		
• Paid By Plan After Deductible	80%	60%
Emergency Room / Emergency Physicians:		
• Paid By Plan After Deductible	80%	80% (True ER) 60% (Non-True ER)

	IN-NETWORK	OUT-OF-NETWORK
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility:		
• Maximum Days Per Calendar Year	60 Days	
• Paid By Plan After Deductible	80%	60%
External Breast Prosthesis:		
• Maximum Benefit Every 3 Years	1 Prosthesis	
• Paid By Plan After Deductible	80%	60%
Hearing Services:		
• Paid By Plan After Deductible	80%	60%
Hearing Aids:		
• Maximum Benefit Per Ear Every 3 Years	$1,400	
• Paid By Plan After Deductible	80% (Deductible Waived)	80% (Deductible Waived)
Home Health Care Benefits:		
• Maximum Visits Per Calendar Year	60 Visits	
• Paid By Plan After Deductible	80%	60%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits:		
Hospice Services:		
• Maximum Benefit Per Lifetime	$5,000	
• Paid By Plan After Deductible	80%	60%
Bereavement Counseling:		
• Maximum Benefit Per Course Of Treatment (Death)	$500	
• Paid By Plan After Deductible	80%	60%
Hospital Services:		
Pre-admission Testing:		
• Paid By Plan After Deductible	80%	60%
Inpatient Services Only:		
• Co-pay Per Admission	Not Applicable	$200
• Paid By Plan After Deductible	80%	60%
Inpatient Physician Charges Only:		
• Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges (Including All Related Charges 2 Weeks Prior and 2 Weeks After For the Physician's Office Or Outpatient Hospital Charges):		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Mental Health, Substance Abuse And Chemical Dependency Benefits:		
Inpatient Services Only:		
• Co-pay Per Admission	Not Applicable	$200
• Paid By Plan After Deductible	80%	60%
Inpatient Physician Charges Only:		
• Paid By Plan After Deductible	80%	60%
Residential Services Only:		
• Co-pay Per Admission	Not Applicable	$200
• Paid By Plan After Deductible	80%	60%
Residential Physician Charges Only:		
• Paid By Plan After Deductible	80%	60%
Outpatient Or Partial Hospitalization:		
• Paid By Plan After Deductible	80%	60%
Inpatient Services Only:		
• Co-pay Per Admission	Not Applicable	$200
• Paid By Plan After Deductible	80%	60%
Office Visit:		
• Paid By Plan After Deductible	80%	60%
Nutrition Counseling:		
• Maximum Benefit Per Calendar Year For Diabetic	1 Course Of Treatment	
• Maximum Visits Per Calendar Year For Nutritional	2 Visits	
• Paid By Plan After Deductible	80%	60%
Physician Office Services:		
Physician Services (General Practitioner, Family Practice, Internal Medicine, Physician Assistant And Pediatrician):		
• Co-pay Per Visit	$30	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Specialist Services:		
• Paid By Plan After Deductible	80%	60%
Office Surgery:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Allergy Injections:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Charges For A Radiologist, Anesthesiologist Or Pathologist While In The Physician's Office:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Private Duty Nursing:		
• Maximum Benefit Per Calendar Year	$2,500	
• Paid By Plan After Deductible	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		No Benefit
From Age 19		
• Maximum Benefit Per Calendar Year	$300	
Preventive / Routine Physical Exams		
Included in Maximum		
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	
Immunizations (Flu, Flumist And Administration Of H1N1 Vaccine Only):		
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Included in Maximum		
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Mammograms And Breast Exams:		
From Age 35		
• Maximum Exams Per Calendar Year	1 Exam	
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Pelvic Exams And Pap Test:		
• Maximum Exams Per Calendar Year	1 Exam	
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine PSA Test And Prostate Exams:		
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
• Physician Office Co-pay Per Exam	$30	
• Paid By Plan	100% (Deductible Waived)	

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits For Children Include: To Age 19		No Benefit
Preventive / Routine Physical Exams: • Physician Office Co-pay Per Exam • Paid By Plan	$30 100% (Deductible Waived)	
Immunizations Including Administration of H1N1 Vaccine: • Physician Office Co-pay Per Exam • Paid By Plan	$30 100% (Deductible Waived)	
Preventive / Routine Diagnostic Tests, Lab And X-rays: • Physician Office Co-pay Per Exam • Paid By Plan	$30 100% (Deductible Waived)	
Preventive / Routine Hearing Exam: • Physician Office Co-pay Per Exam • Paid By Plan	$30 100% (Deductible Waived)	
Rehabilitation Facility: • Maximum Days Per Calendar Year • Paid By Plan After Deductible	60 Days 80%	60%
Second Surgical Opinion: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Support Stockings Such As Jobst Stockings: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	2 Pair 80%	60%
Temporomandibular Joint Disorder Benefits: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	$2,000 80%	60%
Therapy Services: **Occupational / Physical Outpatient Hospital And Office Therapy:** • Paid By Plan After Deductible ***Note: Clinical Eligibility For Coverage Will Be Reviewed After 25 Visits For Occupational / Physical Outpatient Hospital And Office Therapy*** **Speech Outpatient Hospital And Office Therapy:** • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	 80% $500 80%	 60% 60%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	1 Wig 80%	60%
All Other Covered Expenses: • Paid By Plan After Deductible	80%	60%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 002, 003, 004

All health benefits shown on this Schedule of Benefits are subject to the following: Lifetime and annual maximums, individual and family Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and Covered Benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Notification may be required before benefits will be considered for payment. Failure to obtain notification may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and notification procedures.

	TRADITIONAL PLAN
Individual Lifetime Maximum Benefit Excluding Prescription Benefits	$5,000,000
Annual Deductible Per Calendar Year Benefit:	
• Per Person	$500
• Per Family	$1,000
Plan Participation Rate, Unless Otherwise Stated Below:	
• Paid By Plan After Satisfaction Of Deductible	80%
Annual Out-Of-Pocket Maximum:	
• Per Person	$2,500
• Per Family	$5,000
Ambulance Transportation:	
• Maximum Benefit Per Calendar Year	$1,000
• Paid By Plan	80% (Deductible Waived)
Chiropractic Services:	
• Maximum Visits Per Calendar Year	50 Visits
• Maximum Benefit Per Visit	$25
• Paid By Plan After Deductible	80%
Durable Medical Equipment:	
• Paid By Plan After Deductible	80%
Emergency Services / Treatment:	
Urgent Care:	
• Paid By Plan After Deductible	80%
Emergency Room / Emergency Physicians:	
• Paid By Plan After Deductible	80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility:	
• Maximum Days Per Calendar Year	60 Days
• Paid By Plan After Deductible	80%

	TRADITIONAL PLAN
External Breast Prosthesis:	
• Maximum Benefit Every 3 Years	1 Prosthesis
• Paid By Plan After Deductible	80%
Hearing Services:	
• Paid By Plan After Deductible	80%
Hearing Aids:	
• Maximum Benefit Per Ear Every 3 Years	$1,400
• Paid By Plan After Deductible	80%
Home Health Care Benefits:	
• Maximum Visits Per Calendar Year	60 Visits
• Paid By Plan After Deductible	80%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours of Home Health Care Services.	
Hospice Care Benefits:	
Hospice Services:	
• Maximum Benefit Per Lifetime	$5,000
• Paid By Plan After Deductible	80%
Bereavement Counseling:	
• Maximum Benefit Per Course Of Treatment (Death)	$500
• Paid By Plan After Deductible	80%
Hospital Services:	
Pre-admission Testing:	
• Paid By Plan After Deductible	80%
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:	
• Paid By Plan After Deductible	80%
Outpatient Services / Outpatient Physician Charges:	
• Paid By Plan After Deductible	80%
Outpatient Lab And X-ray Charges:	
• Paid By Plan After Deductible	80%
Outpatient Surgery / Surgeon Charges (Including All Related Charges 2 Weeks Prior and 2 Weeks After For the Physician's Office Or Outpatient Hospital Charges):	
• Paid By Plan	100% (Deductible Waived)
Mental Health, Substance Abuse And Chemical Dependency Benefits:	
• Paid By Plan After Deductible	80%

	TRADITIONAL PLAN
Nutrition Counseling:	
• Maximum Benefit Per Calendar Year For Diabetic	1 Course Of Treatment
• Maximum Visits Per Calendar Year For Nutritional	2 Visits
• Paid By Plan After Deductible	80%
Physician Office Services:	
Physician Services (General Practitioner, Family Practice, Internal Medicine, Physician Assistant And Pediatrician):	
• Co-pay Per Visit	$30
• Paid By Plan	100% (Deductible Waived)
Specialist Services:	
• Paid By Plan After Deductible	80%
Office Surgery:	
• Paid By Plan	100% (Deductible Waived)
Allergy Injections:	
• Paid By Plan	100% (Deductible Waived)
Charges For A Radiologist, Anesthesiologist Or Pathologist While In The Physician's Office:	
• Paid By Plan	100% (Deductible Waived)
Private Duty Nursing:	
• Maximum Benefit Per Calendar Year	$2,500
• Paid By Plan After Deductible	80%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:	
From Age 19	
• Maximum Benefit Per Calendar Year	$300
Preventive / Routine Physical Exams:	
Included in Maximum	|
• Physician Office Co-pay Per Visit	$30
• Paid By Plan	100% (Deductible Waived)
Immunizations (Flu, Flumist And Administration Of H1N1 Vaccine:	
• Physician Office Co-pay Per Visit	$30
• Paid By Plan	100% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays:	
Included in Maximum	|
• Physician Office Co-pay Per Visit	$30
• Paid By Plan	100% (Deductible Waived)
Preventive / Routine Mammograms And Breast Exams:	
From Age 35	
• Maximum Exams Per Calendar Year	1 Exam
• Physician Office Co-pay Per Exam	$30
• Paid By Plan	100% (Deductible Waived)

	TRADITIONAL PLAN
Preventive / Routine Pelvic Exams And Pap Test:	
• Maximum Exams Per Calendar Year	1 Exam
• Physician Office Co-pay Per Exam	$30
• Paid By Plan	100% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams: From Age 40	
• Maximum Exams Per Calendar Year	1 Exam
• Physician Office Co-pay Per Exam	$30
• Paid By Plan	100% (Deductible Waived)
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:	
• Physician Office Co-pay Per Exam	$30
• Paid By Plan	100% (Deductible Waived)
Preventive / Routine Care Benefits For Children Include: To Age 19	
Preventive / Routine Physical Exams:	
• Physician Office Co-pay Per Exam	$30
• Paid By Plan	100% (Deductible Waived)
Immunizations Including Administration Of H1N1 Vaccine:	
• Physician Office Co-pay Per Exam	$30
• Paid By Plan	100% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays:	
• Physician Office Co-pay Per Exam	$30
• Paid By Plan	100% (Deductible Waived)
Preventive / Routine Hearing Exam:	
• Physician Office Co-pay Per Exam	$30
• Paid By Plan	100% (Deductible Waived)
Rehabilitation Facility:	
• Maximum Days Per Calendar Year	60 Days
• Paid By Plan After Deductible	80%
Second Surgical Opinion:	
• Paid By Plan	100% (Deductible Waived)
Support Stockings Such As Jobst Stockings:	
• Maximum Benefit Per Calendar Year	2 Pair
• Paid By Plan After Deductible	80%
Temporomandibular Joint Disorder Benefits:	
• Maximum Benefit Per Lifetime	$2,000
• Paid By Plan After Deductible	80%

	TRADITIONAL PLAN
Therapy Services:	
Occupational / Physical Outpatient Hospital And Office Therapy:	
• Paid By Plan After Deductible	80%
Note: Clinical Eligibility For Coverage Will Be Reviewed After 25 Visits For Occupational / Physical Outpatient Hospital And Office Therapy	
Speech Outpatient Hospital And Office Therapy:	
• Maximum Benefit Per Lifetime	$500
• Paid By Plan After Deductible	80%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment And Alopecia Areata:	
• Maximum Benefit Per Lifetime	1 Wig
• Paid By Plan After Deductible	80%
All Other Covered Expenses:	
• Paid By Plan After Deductible	80%

PRESCRIPTION DRUG PROGRAM	
ASP Retirees – Who Retired Under The ASP Contributory System Before January 1, 1978*	
Pharmacy Option	
Prescription Drug Card • Co-pay Per 34 Days	100% After Co-pay Tier 1: $10 Co-pay Tier 2: $30 Co-pay Tier 3: $50 Co-pay
Limitation: 34 days supply on non-maintenance drugs 90 days supply on maintenance drugs	
If a non-participating pharmacy is used, the Covered Person will be responsible for the Co-pay, plus the difference in cost between the participating pharmacy and non-participating pharmacy.	
If the Covered Person purchases a brand name drug when the Physician has indicated a generic drug can be dispensed, the Covered Person will be required to pay the difference between the cost of the generic drug and the brand name requested, plus the usual Co-pay.	

Refer to Prescription Drug Program for complete details.

*Applies to Retired Employee only, excludes spouse or Dependents who are covered as any other member of the Plan.

PRESCRIPTION DRUG PROGRAM	
Active Personnel and ASP Retirees Who Retired Under The Non-Contributory System After January 1, 1978	
Pharmacy Option	
Prescription Drug Card • Co-pay Per 34 Days	100% After Co-pay Tier 1: $10 Co-pay Tier 2: $35 Co-pay Tier 3: $60 Co-pay
Limitation: 34 days supply on non-maintenance drugs 90 days supply on maintenance drugs	
If a non-participating pharmacy is used, the Covered Person will be responsible for the Co-pay, plus the difference in cost between the participating pharmacy and non-participating pharmacy.	
If the Covered Person purchases a brand name drug when the Physician has indicated a generic drug can be dispensed, the Covered Person will be required to pay the difference between the cost of the generic drug and the brand name requested, plus the usual Co-pay.	

Refer to Prescription Drug Program for complete details.

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 001, 002, 003, 004	
Transplant Services At A Designated Transplant Facility:	
Transplant Services: • Paid By Plan After Deductible	 80%
Travel And Housing: • Maximum Benefit Per Transplant • Paid By Plan After Deductible	 $10,000 80%
Travel And Housing At Designated Transplant Facility For Up To One Year From Date Of Transplant.	

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles or out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at an in-network provider will apply to the in-network total individual and family Deductible. The Deductible amounts that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total individual and family Deductible. **(Applies to Benefit Plan(s) 001)**

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

All Covered Expenses which are Incurred during the last three months of a Plan Year and applied toward satisfaction of the individual Deductible for that year, will also be applied toward the individual Deductible requirement for the next Plan Year.

If two or more covered family members are injured in the same Accident, only one Deductible needs to be met for those Covered Expenses which are due to that Accident, and Incurred during that calendar year.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs do not apply toward the out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Co-pays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Co-pays and Participation amounts for Prescription products.
- Expenses Incurred as a result of failure to comply with notification requirements for Hospital confinement.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum. **(Applies to Benefit Plan(s) 001)**

INDIVIDUAL LIFETIME MAXIMUM BENEFIT

All Covered Expenses excluding pharmacy expenses will count toward the Covered Person's individual medical Lifetime Maximum Benefit that is shown on the Schedule of Benefits.

The Schedule of Benefits contains separate Maximum Benefit limitations for specified conditions. All separate Maximum Benefits are part of, and not in addition to, the Maximum Benefit.

For Covered Persons who were terminated from the Plan and are later reinstated after a lapse in coverage (for example, a Covered Person ends employment and later is re-hired and re-enrolls in this Plan), the Lifetime Maximum Benefit will not start over. The Lifetime Maximum Benefit will continue to accumulate from the level satisfied at the time of Covered Person’s termination.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any “fee forgiveness”, “not out-of-pocket” or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person’s claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

An Employee must file a written application with the employer for coverage hereunder for his eligible Dependents. The Employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder. However, if Dependent coverage is already in force at the time of birth, a newborn Child will be automatically added for coverage and no additional enrollment is required.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time 40 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Temporary or leased employees.
- An Independent Contractor as defined in this Plan.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

An eligible Employee who is covered under this Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution for Employee and / or Dependent coverage and must purchase Medicare A & B. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage. While the employer expects Retiree coverage to continue, the employer reserves the right to modify or discontinue Retiree coverage or any other provision of the Plan at any time. The Retiree must submit a copy of their or their spouse's Medicare Card to the Plan Administrator.

An **eligible Dependent** includes:

- Your legal spouse who is a husband or wife of the opposite sex in accordance with the federal Defense of Marriage Act provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a common-law marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- A Dependent Child until the Child reaches his or her 19th birthday. The term "**Child**" includes the following Dependents who meet the eligibility criteria listed below:

  - A natural biological Child;
  - A step Child for whom an Employee's spouse has legal custody or has a legal obligation to provide medical insurance;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 18 as of the date of such placement;
  - A Child under Your (or Your spouse's) permanent or temporary Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
  - A grandchild in the permanent custody of the Employee, provided they reside in the Employee's household and the Employee is acting as a parent.

- A Dependent does not include the following:

  - A Child who is under the age of 19, working full-time and eligible for benefits under their employer;
  - A foster Child;
  - A Child of a Domestic partner or under Your Domestic Partner's Legal Guardianship;
  - Domestic Partners;
  - Any other relative or individual unless explicitly covered by this Plan.

  Eligibility Criteria: To be an eligible Dependent Child, the following conditions must all be met:

  - A Dependent Child must be dependent upon the Employee for more than 50 percent support and maintenance. The financial requirement does not apply to Children who are enrolled in accordance with a QMCSO because of the Employee's divorce or separation decree.
  - A Dependent Child must be unmarried.
  - If both the husband and wife are Employees, they may choose to have one covered as the Employee, and the spouse covered as the Dependent of the Employee, or they may choose to have both covered as Employees. Eligible Children will be enrolled as Dependents of one or both spouses.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 19th birthday; or
- The Dependent Child is a Dependent of an employee newly eligible for the Plan; or
- The Dependent Child is eligible due to Qualifying Status Change event, as outlined in the Section 125 Plan.

and the Dependent Child fits either of the following two categories:

- A covered Dependent Child who is attending high school, a licensed trade school, or an Accredited Institution of Higher Education as a Full-Time Student will continue to be eligible until the Child turns age 25 or until the Dependent Child no longer attends school as a Full-Time Student, whichever is earlier. Extended coverage for Dependent Children who have not reached age 25 will terminate at the end of the month that the Dependent Child is no longer attending or enrolled as a Full-Time Student. A Full-Time Student who is enrolled and begins attending school during any semester, but cannot continue due to Illness or Injury will continue to be covered for the remainder of the semester. (See below for more information on Loss of Full-Time Student Status due to medical necessity) The Plan may require proof of the Dependent Child's Full-Time Student enrollment on an as needed basis. A Full-Time Student who finishes the spring term shall be deemed a Full-Time Student throughout the summer if the Student has enrolled as a Full-Time Student for the following fall term, regardless of whether or not such Student enrolls for the summer term.

  A Dependent Child may enroll in the Plan at the beginning of the semester if the Dependent Child qualifies due to initial or re-enrollment as a Full-Time Student. The Dependent shall be effective the first full day the Dependent returns to class;

or

- If You have a Dependent Child covered under this Plan who is under the age of 19 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

  - The Dependent must not be able to hold a self-sustaining job due to the disability; and
  - Proof must be submitted as required; and
  - The Employee must still be covered under this Plan.

  A Totally Disabled Dependent Child older than 19 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

Loss of Full-Time Status Due to Medical Necessity

Dependents who are enrolled in a licensed trade school, or an Accredited Institution of Higher Education on the day before the first day of a medically necessary leave of absence or reduction in full-time status will be entitled to up to twelve months of coverage continuation. To qualify:

- The Plan received written certification from the Dependent's treating Physician stating that the Child is suffering from a serious Illness or Injury and that a leave or reduction in enrollment is medically necessary.

- The leave must begin while the Dependent is suffering from a serious Illness or Injury and be medically necessary.

Coverage during a medically necessary leave of absence will be the same as if the Child remained a Full-Time Student and will continue for up to one year from the date the medically necessary leave began or until the Dependent would otherwise lose eligibility under the Plan, whichever is sooner. In addition, if any changes are made to the Plan during the medically necessary leave, the Dependent Child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as Dependent Children are still covered by the Plan.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to attend school as a Full-Time Student for reasons other than minor, short-term Illness or Injury or medical necessity (as described above), or the Dependent does not meet the qualifications of Totally Disabled, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Section in this document.

(Applies to Class(es) R01, R02, X01, X02) Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If You apply within 30 days of hire, Your coverage will become effective the first day of continuous full-time service in an eligible class; or

- If You apply after 30 days of hire, You will be considered a Late Enrollee. You or Your Dependent must provide evidence of good health satisfactory to the Employer, at Your cost. Coverage for a Late Enrollee will become effective the first day of the month coinciding with or following the date of approval.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 31 days of acquiring the Dependent; or

- The first day of the month coinciding with or following the date of approval if the Dependent is a Late Enrollee. You or Your Dependent must provide evidence of good health satisfactory to the Employer, at Your cost. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 31 days following the date You acquire the Dependent; or

- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

TERMINATION

For information about continuing coverage, refer to the COBRA section of this SPD.

EMPLOYEE'S COVERAGE (Applies to Class(es) A01, A02, C01, C02)

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, or
- The day of the month in which You are no longer a member of a covered class, as determined by the employer except as follows:
  - If You are temporarily absent from work due to a layoff, suspension or an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to six months, provided that the applicable Employee contribution is paid when due.
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section; or
- The day of the month in which Your employment ends; or
- The date in which You reach Your individual Lifetime Maximum Benefit under this Plan; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

EMPLOYEE'S COVERAGE (Applies to Class(es) R01, R02, X01, X02)

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status; or
- The last day of the month in which You are no longer a member of a covered class, as determined by the employer except if You are temporarily absent from work due to active military duty. Refer to USERRA under the USERRA section; or
- The date in which You reach Your individual Lifetime Maximum Benefit under this Plan; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends except in the event that the Employee dies, Your Dependent will be treated as a Retiree and coverage for the Dependent can continue indefinitely, however they pay the full cost of coverage.
- The day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section, unless the Child qualifies for Extended Dependent Coverage; or
- If Your Dependent Child qualifies for Extended Dependent Coverage as a Full-Time Student, the day of the month in which your Dependent Child no longer qualifies as a Full-Time Student unless the Dependent Child qualifies for a medically necessary leave of absence (see Extended Dependent Coverage section for more information) or the day of the month Your Dependent Child turns 25, whichever is earlier; or
- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
- The day of the month in which Your Dependent Child no longer satisfies a required eligibility criteria listed in the Enrollment Section; or
- The date Dependent coverage is no longer offered under this Plan; or
- The day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status; or
- The date in which the Dependent reaches the individual Lifetime Maximum Benefit under this Plan; or
- The day of the month in which the Dependent becomes covered as an Employee under this Plan; or
- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, lay-off, or suspension and You qualify for eligibility under this Plan again at a later date, You must meet all requirements of a new Employee. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact Your Human Resources or Personnel office.

PRE-EXISTING CONDITION PROVISION

A Pre-Existing Condition means a condition or Injury which existed within a 12 month period prior to the Covered Person's effective date. A condition or Illness is considered to have existed if it caused symptoms and those symptoms would ordinarily cause a person of good judgment to seek diagnoses, care and treatment for such condition or Illness. Pregnancy is considered a Pre-Existing Condition if conception occurs before the Covered Person's effective date. This exclusion will not apply to charges Incurred after the end of a 12 consecutive month period beginning with the effective date of coverage after the individual has been covered under the Plan for 12 consecutive months.

This Plan has an exclusion for Pre-Existing Conditions. Benefits will not be paid for Covered Expenses for a Pre-Existing Condition until the earliest of the following:

- 12 consecutive months from the Covered Person's Enrollment Date, if You apply for coverage when You are initially eligible for coverage; or

- 12 consecutive months from the Covered Person's Enrollment Date, if the Covered Person is considered a Late Enrollee.

EXCEPTIONS

The Pre-Existing Condition exclusion does not apply to:

- The Covered Person if the Covered Person is covered on the effective date of this Plan; and

- The Covered Person was covered on the immediately preceding day under the policy which was replaced by this Plan; and

- Such expenses would have been payable under the policy or plan which was replaced by this Plan, the total amount payable for the excluded expenses would be the lesser of:

  - The policy or plan replaced, or
  - This Plan

- Genetic information, in the absence of a diagnosis of an Illness related to such information. For example, if You have a family history of diabetes but You Yourself have had no problem with diabetes, the Plan will not consider diabetes to be a Pre-Existing Condition just because You have a family history of this disease.

- Treatment recommendations made prior to the twelve consecutive month period before the Enrollment Date when the Covered Person did not act upon the recommendation.

- Any Employees or Dependents added as a result of an acquisition of an entire company or entire division moving into this Plan will be effective upon notification by the Employer to the Plan Administrator. The Pre-Existing Condition exclusion period under this Plan will apply. However, the Plan Administrator, in its discretion, may waive the Pre-Existing Condition exclusion period with respect to all similarly situated Employees who were covered under the other employer's group health plan at the time of such acquisition and/or honor any shorter Pre-Existing Condition exclusion period contained in such other employer's group health plan.

Pre-notification does not constitute Plan liability for any Pre-Existing Condition charges during this Pre-Existing Condition limitation period.

For the purpose of determining whether this Pre-Existing Condition Provision of the Plan will be applied to claims for any individual, the Plan administrator will look to the period of time the individual has been covered under this Plan.

The Covered Person has a right to appeal the determination of coverage for Pre-Existing Conditions. See Claim Filing Procedures.

THE RIGHT TO REQUEST A REVIEW OF A DETERMINATION OF PRE-EXISTING CONDITION EXCLUSION PERIOD

If a Covered Person feels that a determination of the Pre-Existing Condition Exclusion (PCE) period is incorrect, the Covered Person may submit a written request for review.

Send Your request to:

UMR
ENROLLMENT SERVICES
PO BOX 30543
SALT LAKE CITY UT 84130-0543

The written request must be made within 60 days from the date of the notice.

The written request should state the reasons that the Covered Person believes the original determination is incorrect.

The request will usually be decided within 60 days after it is submitted. If additional time is needed to complete the review, the Covered Person will be notified. The Covered Person will be notified in writing of the decision on the request if the Covered Person submits additional evidence to consider or if the original Determination of PCE period is modified. The Covered Person's original determination of PCE period will remain in effect until or unless the Covered Person receives written notification verifying a change from the original decision.

Similar to an initial determination, any new determination will set forth:

- The specific reason(s) for the decision; and
- The specific Plan provision(s) and other documents or information on which the decision is based.

HIPAA PORTABILITY RIGHTS

CERTIFICATES OF CREDITABLE COVERAGE

Covered Persons will receive a Certificate of Creditable Coverage from this Plan when the person loses coverage under this Plan, when the person loses COBRA coverage, or upon a written request to this Plan if the individual is covered under this Plan or terminated from this Plan within the previous twenty four month period. The Certificate of Creditable Coverage is evidence of Your coverage under this Plan. Covered Persons may need evidence of coverage to reduce a Pre-Existing Condition exclusion period under another plan, to help get special enrollment in another plan, or to get certain types of individual health coverage.

Please submit written requests for a Certificate of Creditable Coverage from this Plan to:

DATAPATH
1601 WESTPARK DR
LITTLE ROCK AR 72204

Keep these Certificates in a safe place in case You or Your Dependents obtain coverage under another health plan that has a Pre-Existing Condition Exclusion Provision or become eligible for a Special Enrollment period under another plan. Proof of prior Creditable Coverage may reduce or eliminate the Pre-Existing Condition exclusion period, may be required to enroll in another plan under Special Enrollment, or may assist individuals in obtaining an individual insurance policy in the future.

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

The COBRA Administrator for this Plan is: Datapath

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

Qualifying Event	**Length of Continuation**
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from Your spouse	up to 36 months

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child stops being eligible for coverage under the plan as a Dependent	up to 36 months

COBRA continuation coverage for Retired Employees and their Dependents is described below:

• If You are a Retired Employee and Your coverage is reduced or terminated due to Your Medicare entitlement, and as a result Your Dependent's coverage is also terminated, Your spouse and Dependent Children will also become Qualified Beneficiaries.	up to 36 months
• If You are a Retired Employee and Your employer files bankruptcy under Title 11 of the United States Code this may be a Qualifying Event. If the bankruptcy results in Loss of Coverage under this Plan, then the Retired Employee is a Qualified Beneficiary. The Retired Employee's spouse, surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.	
➢ Retired Employee	Lifetime
➢ Dependents	36 months

Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the Employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred or will occur.

Send all notices or other information required to be provided by this Summary Plan Description in writing to:

DATAPATH
1601 WESTPARK DR
LITTLE ROCK AR 72204

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would lose coverage); or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will be effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary marries.
- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary.
- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- The date any Qualified Beneficiary becomes covered by another group health plan.
- Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)
- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:
  - Employee's death.
  - Employee's divorce or legal separation.
  - Former Employee becomes enrolled in Medicare.
  - A Dependent Child no longer being a Dependent as defined in the Plan.
- For Retired Employees and Dependents of Retired Employees only. If bankruptcy of the employer is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries can continue COBRA continuation coverage for the following maximum period, subject to all COBRA regulations. The covered Retired Employee can continue COBRA coverage for the rest of his or her life. The covered spouse, surviving spouse or Dependent Child of the covered Retired Employee can continue coverage until the earlier of:
  - The date the Qualified Beneficiary dies; or
  - The date that is 36 months after the death of the covered Retired Employee.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled some time before the 60th day of COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualifying Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the Qualifying Event or the date that Plan coverage was lost; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan that the Qualified Beneficiary is under, but still maintains another group health plan for other similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).

- The required contribution for the Qualified Beneficiary's coverage is not paid on time.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition(s) for the beneficiary.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

Electing COBRA continuation coverage now may protect some of Your (or Your Dependent's) rights if You or Your Dependent need to obtain an **individual health insurance policy** soon. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing Pre-Existing Condition exclusions, under certain conditions. Some of those conditions pertain to COBRA continuation coverage. To take advantage of this HIPAA right, COBRA continuation coverage under this Plan must be elected and maintained (by paying the cost of coverage) for the duration of the COBRA continuation period. In the event that an individual health insurance policy is needed, You or Your Dependent must apply for coverage with an individual insurance carrier after COBRA continuation coverage is exhausted and before a 63-day break in coverage.

If You or Your Dependent will be obtaining **group health coverage** through a new employer, keep in mind that HIPAA requires employers to reduce Pre-Existing Condition exclusion periods if there is less than a 63-day break in health coverage (Creditable Coverage).

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (COBRA Subsidy)

Note: This provision will automatically terminate on 12-31-2011, and benefits outlined will no longer be available without further Plan amendment.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act of 2010 ("Defense Act"), the Temporary Extension Act of 2010 ("TEA"), the Continuing Extension Act of 2010, and any future applicable legislation, reduces the COBRA premium in some cases. If a Covered Person experienced a Loss of Coverage due to involuntary termination by the Employer during the period that begins with September 1, 2008 and ends with May 31, 2010, the Covered Person may be eligible for the temporary premium reduction for up to fifteen months.

ELIGIBLE INDIVIDUALS

Covered Persons and their Dependents who experienced a Loss of Coverage under the Plan due to an involuntary termination of employment between September 1, 2008 and May 31, 2010 or is an individual who experiences a Qualifying Event that is a reduction of hours occurring at any time from September 1, 2008 and May 31, 2010, which is followed by an involuntary termination of employment on or after March 2, 2010 through May 31, 2010 and as a result, fit the definition of Qualified Beneficiary under COBRA are eligible. These individuals may also be referred to as Assistance Eligible Individuals (AEIs).

Some AEIs will have declined COBRA prior to passage of the law or elected COBRA but then dropped coverage prior to passage of the law. These AEIs will have a second opportunity to elect COBRA coverage and take advantage of the premium subsidy (reduced premium).

Some AEIs who have exhausted their 9 month subsidy period prior to December 19, 2009 and who failed to pay the premium during the transition period may be eligible to retroactively reinstate coverage provided that they pay the reduced premium for such coverage within 60 days of the date of the enactment (in which case the due date would be February 17, 2010) or if later, 30 days after the date the notice is provided. The transition period is any period of coverage that begins prior to December 19, 2009 and is subject to the extension.

In addition, any AEI who exhausted their 9 month subsidy period prior to the date of enactment of the "Defense Act", and then subsequently paid the full premium during the transition period (the period of coverage that begins prior to December 19, 2009) are entitled to a refund or credit as prescribed by the original ARRA legislation.

An AEI that is eligible for the subsidy as a result of a reduction of hours that is followed by an involuntary termination of employment will have his or her maximum COBRA coverage measured from the date of the reduction in hours. This means that upon the later involuntary termination of employment, the individual can elect COBRA coverage only for the remainder of the original COBRA coverage period which began upon the reduction of hours of employment. Please refer to Your COBRA election form for additional information regarding Your rights to COBRA.

Assistance Eligible Individuals must not be eligible for coverage under any other group health plan (other than certain limited plans). This includes eligibility for coverage under a spouse's employer's plan or Medicare. Failure to notify the Plan of eligibility under any other group health plan can result in significant penalties.

The subsidy will be phased out starting with taxpayers whose modified adjusted gross income exceeds $125,000 ($250,000 in the case of a joint return). This means a percentage of the subsidy will be recaptured in the federal income taxes imposed on individuals making more than $125,000 ($250,000 in the case of a joint return). Higher income individuals $145,000 ($290,000 in the case of a joint return) can make an election to waive the subsidy in the manner and form set forth by the Secretary of the Treasury.

AMOUNT AND LENGTH OF SUBSIDY

Assistance Eligible Individuals will be responsible for only 35% of the amount of their COBRA premium. That means a Qualified Beneficiary whose normal full COBRA premium would be $500 per month would be responsible for paying only $175 per month for the qualifying time period.

The subsidy period ends at the earliest following date:

- Fifteen months after the date the individual becomes eligible for the subsidy.
- The Qualified Beneficiary becomes eligible for coverage under any other group health plan (other than certain limited plans) or becomes eligible for Medicare. This also includes eligibility for coverage under a spouse's employer's plan. The Qualified Beneficiary must notify the administrator in writing of such eligibility as set forth by the Department of Labor (DOL). Failure of the Qualified Beneficiary to notify the administrator may result in a penalty of 110% of the premium reduction provided after termination.
- The Qualified Beneficiary's maximum period of continuation coverage required under the applicable COBRA continuation coverage provision is met. Note that for those Qualified Beneficiaries receiving a second opportunity to elect coverage, the maximum COBRA continuation coverage period runs from the original Qualifying Event.

ELECTING THE SUBSIDY

If You have a Qualifying Event between September 1, 2008 and May 31, 2010 Your COBRA Administrator will send You a formal notification of Your COBRA rights under the American Recovery and Reinvestment Act, as amended. The notification will include the necessary forms and instructions on how to elect to receive the subsidy as applicable.

If it is determined that You are not an AEI, and You disagree with this determination, You may appeal this determination with the DOL in the manner and form specified by them. Please see http://www.dol.gov/ebsa/subsidydenialreview.html. State and local government Employees should contact HHS-CMS at www.cms.hhs.gov/COBRAContinuationofCov/ or NewCobraRights@cms.hhs.gov.

If You have any questions about Your rights to COBRA continuation coverage, You should contact

DATAPATH
1601 WESTPARK DR
LITTLE ROCK AR 72204

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to Pre-Existing Conditions and Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

If an Employee or an Employee's Dependent is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the Employee or the Employee's Dependent may continue their health coverage, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

The period of continuation of coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the Employee or the Employee's Dependent will be reinstated without Pre-Existing Conditions exclusions or a Waiting Period.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents may be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK
(Applies to Benefit Plan(s) 001)

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. In all cases the network contract determines what the Plan will consider as a Covered Expense. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  58 – UnitedHealthcare Options PPO Network

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim than they would for an Out-of-Network claim.

  ZM – Multiplan Shared Savings

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

For Transplant Services at a Designated Transplant Facility the Preferred Provider Organization is:

OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Usual and Customary charge limitations. The following exceptions may apply:

- Emergency treatment rendered at an Out-of-Network facility. If the Covered person is admitted to the hospital on an emergency basis, covered expenses shall be payable at the In-Network level.
- Out-of-Network anesthesiologist and/or assistant surgeon if the operating surgeon is In-Network and when the facility rendering such services is In-Network, covered expenses shall by payable at the In-Network level.

- Covered Services provided by a radiologist, anesthesiologist, or pathologist when services are provided at a Network facility or referred by an In-Network provider, even if the provider is an Out-of-Network provider.
- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- While the covered Person is confined to an In-Network hospital, the In-Network Physician requests a consultation from an Out-of-Network provider or a newborn visit as performed by an Out-of-Network Provider, covered expenses shall by payable at the In-Network level.
- When Clinically Eligible services, supplies and treatments not available through any In-Network provider, covered expenses shall by payable at the In-Network level.
- Covered persons who reside 40 miles or further outside the In-Network service area or for emergency treatment rendered while traveling out-of-area.
- Treatment rendered at a facility of the uniformed services or Indian Health Care facility.

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the PPO benefit level by the prior Claims Administrator but which are not considered at the PPO benefit level by the current Claims Administrator may be paid at the applicable PPO benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the PPO medical plan benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

You or Your Dependent must call UMR within 30 days prior to the effective date or within 30 days after the effective date to see if You or Your Dependent are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

PROVIDER NETWORK
(Applies to Benefit Plan(s) 002)

This coverage provides for the use of a provider organization. Benefits are paid at the same level, however UnitedHealthcare Options PPO Network providers have agreed to provide certain discounts on covered services which reduce the Covered Person's out-of-pocket expenses.

The Plan does not limit a Covered Person's right to choose his or her own medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan or is subject to a limitation or exclusion.

To get more information on UnitedHealthcare Options PPO Network providers, call the number on the back of the Plan's identification card.

- **For Transplant Services at a Designated Transplant Facility, the Network is:**

  OptumHealth

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following Covered Benefits if services are authorized by a Physician and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

1. **Abortions:** If a Physician states in writing that:
   - The mother's life would be in danger if the fetus were to be carried to term, or
   - Abortion is medically indicated due to complications with the pregnancy; or
   - The pregnancy is a result of rape or incest.

2. **Allergy Treatment** including: injections, testing and serum.

3. **Ambulance Transportation:** When Clinical Eligibility for Coverage is met, ground and air transportation by a vehicle designed, equipped and used only to transport the sick and injured to the nearest medically appropriate Hospital.

4. **Anesthetics and their Administration.**

5. **Breast Prosthesis** shall be covered up to the benefit shown on the Schedule of Benefits unless recommended more frequently by a Physician. The first permanent internal breast prosthesis necessary because of a mastectomy shall also be a Covered Expense.

6. **Breast Reductions** if Clinical Eligibility for Coverage is met.

7. **Cardiac Pulmonary Rehabilitation** when Clinical Eligibility for Coverage is met for Activities of Daily Living (See Glossary of Terms) as well as a result of an Illness or Injury.

8. **Cardiac Rehabilitation** programs are covered if referred by a Physician, for patients who have:

   - had a heart attack in the last 12 months; or
   - had coronary bypass surgery; or
   - a stable angina pectoris.

   Services covered include:

   - Phase I, while the Covered Person is an Inpatient.
   - Phase II, while the Covered Person is in a Physician supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

9. **Cataract or Aphakia Surgery** as well as protective lenses following such procedure.

10. **Chiropractic Treatment** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography, and when Clinical Eligibility for Coverage is met for treatments for musculoskeletal conditions. Refer to Maintenance Therapy under the General Exclusions section of this SPD.

11. **Circumcision** and related expenses when care and treatment meet the Clinical Eligibility for Coverage. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

12. **Cleft Palate And Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes oral surgery and pre-graft palatal expander when the Clinical Eligibility for Coverage is met.

13. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at an OptumHealth facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.

14. **Cornea Transplants** are payable at the percentage listed under All Other Covered Expenses on the Schedule of Benefits.

15. **Counseling Services** for diabetic or nutritional counseling if the Clinical Eligibility for Coverage is met.

16. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if the Clinical Eligibility for Coverage is met.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

17. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling. Charges for dialysis for the treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. This also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other Illness.

18. **Durable Medical Equipment:** subject to all of the following:

    - The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment is subject to review under the Utilization Management Provision of this SPD, if applicable.
    - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.

- If the equipment is purchased, benefits will be payable for subsequent repairs including batteries, or replacement only if required:
  - due to the growth or development of a Dependent Child;
  - when necessary because of a change in the Covered Person's physical condition; or
  - because of deterioration caused from normal wear and tear.

  The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.
- This Plan covers taxes, shipping and handling charges for Durable Medical Equipment.

19. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

20. **Extended Care Facility Services:** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. Covered Person must give notification for services in advance. (Refer to the Utilization Management section of this SPD). The following benefits are covered:

    - Room and board.
    - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

21. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease
    - Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.
    - Covered charges do not include Palliative Foot Care.

22. **Genetic Counseling** based on Clinical Eligibility for Coverage.

23. **Genetic Testing** based on Clinical Eligibility for Coverage.

24. **Hearing Services** include:

    - Exams, tests, services and supplies including Preventive Care, or to diagnose and treat a medical condition.
    - Purchase or fitting of hearing aids.

25. **Home Health Care Services:** (Refer to Home Health Care section of this SPD).

26. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

    - **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.

- **Respite Care** to provide temporary relief up to four hours per day to the family or other caregivers in the case of an emergency or to provide temporary relief from the daily demands of caring for a terminally ill person. Services must be rendered by an aide who is employed by hospice.
- **Bereavement Counseling:** Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist. The services must be furnished within twelve months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

27. **Hospital Services (Includes Inpatient Services, Surgical Centers And Birthing Centers).** The following benefits are covered:

    - Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only when Clinical Eligibility for Coverage is met. If the Hospital has no semi-private rooms, the Plan will allow the private room rate subject to Usual and Customary charges or the Negotiated Rate, whichever is applicable.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

28. **Hospital Services (Outpatient).**

29. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

30. **Laboratory Or Pathology Tests And Interpretation Charges** for Covered Benefits.

31. **Maternity Benefits** for the Employee or spouse include:

    - Prenatal and postnatal care.
    - Hospital or Birthing Center room and board.
    - Obstetrical fees for routine prenatal care.
    - Vaginal delivery or Cesarean section.
    - Diagnostic testing when Clinical Eligibility for Coverage is met.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Midwifes.
    - In the event of early discharge from a hospital or birthing center following delivery, the Plan will cover two Registered Nurse home visits.

32. **Mental Health Treatment** (Refer to Mental Health section of this SPD).

33. **Modifiers or Reducing Modifiers** if Clinical Eligibility for Coverage is met, apply to services and procedures performed on the same day and may be applied to surgical, radiology and other diagnostic procedures. For providers participating with a primary or secondary network, claims will be paid according to the network contract. For providers who are not participating with a network, where no discount is applied, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure and a percentage (%) of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

34. **Multiple Birth Deductible:** When two or more Dependents are born in a multiple birth, only one individual Deductible will be taken from the total Covered Expenses Incurred in a calendar year for those Dependents if the Covered Expenses are Incurred in the same calendar year as the birth and are due to:

    - Premature birth; or
    - Abnormal congenital conditions; or
    - Injury which is Incurred or Illness which starts not more than thirty (30) days after birth.

35. **Nursery And Newborn Expenses Including Circumcision** are covered for the following Children of all Covered Persons: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

    In the event of early discharge from a hospital or birthing center following delivery, the Plan will cover two Registered Nurse home visits.

36. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings) provided the feedings are prescribed by a Physician, and are the sole source of nutrition.

37. **Occupational Therapy.** (See Therapy Services below)

38. **Oral Surgery** includes:

    - Excision of partially or completely impacted teeth.
    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitus.
    - Incision of accessory sinuses, salivary glands or ducts.
    - Excision of exostosis of jaws and hard palate.

39. **Orthognathic, Prognathic And Maxillofacial Surgery** when Clinical Eligibility for Coverage is met.

40. **Orthotic Appliances, Devices and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include supports, trusses, elastic compression stockings, and braces.

41. **Oxygen And Its Administration.**

42. **Pharmacological Medical Case Management** (Medication management and lab charges).

43. **Physical Therapy.** (See Therapy Services below)

44. **Physician Services** for Covered Benefits.

45. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

46. **Prescription Medications** which are administered or dispensed as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

47. **Preventive / Routine Care** as listed under the Schedule of Benefits. This also includes Preventive / Routine Care benefits for Children.

48. **Private Duty Nursing Services** when Outpatient care is required 24 hours a day. This does not include Inpatient private duty nursing services.

49. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

    - Due to the growth or development of a Dependent Child; or
    - When necessary because of a change in the Covered Person's physical condition; or
    - Because of deterioration caused from normal wear and tear.

    The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

50. **Radiation Therapy and Chemotherapy.**

51. **Radiology and Interpretation Charges.**

52. **Reconstructive Surgery** includes:

    - Following a mastectomy (Women's Health and Cancer Rights Act)
      The Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
    - Surgery to restore bodily function that has been impaired by a congenital Illness or anomaly, Accident, or from an infection or other disease of the involved part.

53. **Respiratory Therapy.** (See Therapy Services below)

54. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

55. **Sleep Disorders** if Clinical Eligibility for Coverage is met.

56. **Sleep Studies.**

57. **Speech Therapy.** (See Therapy Services below)

58. **Sterilizations (Voluntary).**

59. **Substance Abuse Services** (Refer to Substance Abuse section of this SPD).

60. **Support Stockings** such as jobst stockings.

61. **Surgery and Assistant Surgeon Services** (See Modifiers or Reducing Modifiers above).

62. **Temporomandibular Joint Disorder (TMJ) Services** includes:

    - Diagnostic services.
    - Surgical treatment.
    - Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

    This does not cover dental services, orthodontic services, or prosthetic devises prescribed by a Physician of dentist.

63. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist.
    - **Physical therapy** by a Qualified physical therapist.
    - **Respiratory therapy** by a Qualified respiratory therapist.
    - **Speech therapy** by a Qualified speech therapist including therapy for stuttering due to a neurological disorder.

64. **Transplant Services** (Refer to Transplant section of this SPD).

65. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

66. **Wigs, Toupees, Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.

67. **X-ray Services** for Covered Benefits.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients who are unable to leave their home, as determined by the Utilization Review Organization. Covered Persons must give notification in advance before receiving services. Please refer to the Utilization Management section of this SPD for more details. Covered services can include:

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietitian.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Clinical Eligibility for Coverage is met) or a single visit by a therapist or a registered dietician.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer To Utilization Management section of this SPD for notification requirements

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician's charges, organ and tissue procurement, tissue typing and Ancillary Services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior notification for all transplant related services. If prior notification is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must meet Clinical Eligibility for Coverage for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Covered Person under this Plan.

If a Covered Person's transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/Pancreas.
- Pancreas, which meets the criteria as determined by the Utilization Management.
- Liver.
- Heart.
- Heart/Lung.
- Lung.
- Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions.
- Small Bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:
  - Airfare.
  - Tolls and parking fees.
  - Gas/Mileage.
- Lodging at or near the transplant facility including:
  - Apartment rental.
  - Hotel rental.
  - Applicable tax.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day, may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will only pay travel and housing benefits for a non-covered living donor after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Transplants considered Experimental, Investigational or Unproven.

- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured.

- Autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for the treatment of but not limited to:

  - Wilm's Tumor.
  - Testicular cancer.
  - Brain tumors of any kind (including but not limited to gliomas, astrocytomas, rhabdomyosarcomas, and peripheral neuroectodermal tumors).
  - Sarcomas.
  - Lung cancers.
  - Ovarian, uterine and cervical cancer.
  - Malignant melanoma and other skin cancer.
  - Cancer of the genitourinary tract including but not limited to prostate and bladder cancer.
  - Peripheral neuroepithelioma.
  - AIDS.
  - Gastrointestinal tract cancer including esophagus, gastric, small intestine, colon.
  - Cancer of the pancreas.
  - Patients with brain metastases.
  - Head and neck cancer.
  - Sickle cell anemia.
  - Immune thrombocytopenic purpura.
  - Multiple sclerosis.

- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to meet Clinical Eligibility for Coverage and/or are not appropriate, as determined by the Plan.

- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION BENEFITS

Administered by LDI Integrated Pharmacy Services

PHARMACY OPTION

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription drugs.

PHARMACY OPTION COPAY

The Co-pay is applied to each covered pharmacy drug charge and is shown on the Schedule of Benefits. The Co-pay amount is not a covered expense under the Medical Expense Benefit. Any one prescription is limited to the greater of a thirty-four (34) day supply or ninety (90) unit doses. Maintenance drugs (drugs which are prescribed for long-term usage) may be dispensed in a ninety (90) day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the Covered Person must pay the entire cost of the Prescription, including Co-pay, and then submit the receipt to the prescription drug card vendor for reimbursement. If a non-participating pharmacy is used, the Covered Person will be responsible for the Co-pay, plus the difference in cost between the participating pharmacy and non-participating pharmacy.

If the Covered Person purchases a brand name drug when the Physician has indicated a generic drug can be dispensed, the Covered Person will be required to pay the difference between the generic drug and the brand name requested, plus the usual Co-pay.

COVERED PRESCRIPTION DRUGS

- Drugs prescribed by a Physician that require a Prescription either by federal or state law, except injectables (other than insulin, Byetta, Symlin and covered self-administered specialty injectables) and drugs excluded by the Plan.
- Compounded Prescriptions containing at least one prescription ingredient with a therapeutic quantity.
- Insulin when prescribed by a Physician.
- A charge for covered acne medications, for Covered Persons up to age twenty-six (26).
- Any other covered drug that, under the applicable state law, may be dispensed only upon the written Prescription of a qualified prescriber.
- Prescription only smoking cessation products, limited to one (1) course of treatment (90 ninety days) per person per lifetime, including but not limited to Zyban and Chantix.

LIMITS TO THIS BENEFIT

This benefit applies only when a Covered Person incurs a covered Prescription drug charge. The covered drug charge for any one Prescription will be limited to:

- Refills only up to the number of times specified by a Physician.
- Refills up to one year from the date of order by a Physician.
- AIDS related medications require prior authorization.

EXPENSES NOT COVERED

- A drug or medicine that can legally be purchased without a written Prescription. This does not apply to injectable insulin.
- Devices of any type, even though such devices may require a Prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments; or any similar device.
- Immunization agents or biological sera, blood or blood plasma.
- A drug or medicine labeled: "Caution – limited by federal law to investigational use."
- Experimental drugs and medicines, even though a charge is made to the Covered Person, including DESI drugs (drugs determined by the FDA as lacking substantial evidence of effectiveness).
- Any charge for the administration of a covered Prescription drug.
- Any drug or medicine that is consumed or administered at the place where it is dispensed.
- A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for dispensing drugs.
- A charge for Prescription drugs which may be properly received without charge under local, state or federal programs.
- A charge for hypodermic syringes and/or needles, injectables or any Prescription directing administration by injection (other than insulin, Byetta, Symlin and other covered self-injectable specialty medications).
- A charge for infertility medication.
- A charge for contraceptive devices.
- A charge for legend vitamins, except pre-natal or pediatric legend vitamins.
- A charge for fluoride supplements.
- A charge for all hair growth or hair reduction agents.
- A charge for growth hormones, except for medically necessary Growth Hormone Therapy prescribed for a documented growth hormone deficiency such as Turner's Syndrome, growth delay due to cranial radiation or chronic renal disease.
- A charge for anti-obesity agents.
- A charge for acne medications, all dosage forms, for Covered Person age twenty-six (26) and over.
- A charge for non-legend drugs, other than as specifically listed herein.
- A charge for Levonorgestrel (Norplant implants).
- A charge for Hematinics.
- A charge for minerals, except for medically necessary Folic Acid (1mg) and Iron.
- A charge for erectile dysfunction medications, aids or devices.

NOTICE OF AUTHORIZED REPRESENTATIVE

The Covered Person may provide the plan administrator (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a Covered Person and consent to release of information related to the Covered Person to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

APPEALING A DENIED POST-SERVICE PRESCRIPTION DRUG CLAIM

The "named fiduciary" for purposes of an appeal of a denied Post-Service Prescription Drug Claim, as described in U.S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the claims processor for medical/dental/vision claims.

A Covered Person, or the Covered Person's authorized representative, may request a review of a denied claim by making written request to the named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the Covered Person feels the claim should not have been denied.

The following describes the review process and rights of the Covered Person:

- The Covered Person has a right to submit documents, information and comments.
- The Covered Person has the right to access, free of charge, relevant information to the claim for benefits.
- The review takes into account all information submitted by the Covered Person, even if it was not considered in the initial benefit determination.
- The review by the named fiduciary will not afford deference to the original denial.
- The named fiduciary will not be:
  - The individual who originally denied the claim, nor
  - Subordinate to the individual who originally denied the claim.
- If the original denial was, in whole or in part, based on medical judgment:
  - The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment; and
  - The professional provider utilized by the named fiduciary will be neither:
    - An individual who was consulted in connection with the original denial of the claim, nor
    - A subordinate of any other professional provider who was consulted in connection with the original denial.
- If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG CLAIM APPEAL

The plan administrator (or its designee) shall provide the Covered Person (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

- The specific reasons for the denial.
- Reference to specific Plan provisions on which the denial is based.
- A statement that the Covered Person has the right to access, free of charge, relevant information to the claim for benefits.
- A statement that if the Covered Person's appeal is denied, the Covered Person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
- If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
  - A copy of that criterion, or
  - A statement that such criterion was relied upon and will be supplied free of charge, upon request.
- If the denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the Plan will supply either:
  - An explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or
  - A statement that such explanation will be supplied free of charge, upon request.

PRESCRIPTION DRUGS

The Plan shall cover Prescription drugs as specified on the Schedule of Benefits. Such drugs must be approved by the Food and Drug Administration and must be dispensed by a licensed pharmacist, Physician or dentist. Antigen and allergy vaccine dispense by a Physician or certified laboratory shall be a Covered Expense. Covered Prescription expense shall exclude oral contraceptives and birth control devices. Norplant implants or similar devices are also excluded. Vitamins, which require a Prescription by law, and are used to treat a specific Illness shall be considered a Covered Expense.

The application of Co-pays or Deductibles under the Prescription Drug Program shall not be considered a Covered Expense under the Medical Expense Benefit.

Prescription drugs shall be covered under the Prescription Drug Program only.

For any Prescription Drug questions, please contact Scrip Solutions at the following:

LDI Integrated Pharmacy Services
680 Craig Rd Ste 200
Creve Coeur MO 63141-7120
866-516-2121

MENTAL HEALTH BENEFITS

The Plan will pay the following Covered Expenses for services authorized by a Physician and deemed to meet the Clinical Eligibility for Coverage for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, maximum fee schedule or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services are payable subject to all of the following:

- The Hospital or facility must be accredited by The Joint Commission (formerly known as JCAHO), or other recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility for the treatment of Mental Health Disorders. If outside of the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates and provides treatment for Mental Health Disorders. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- The Covered Person must have the ability to accept treatment.

- The Covered Person must be suicidal, homicidal, delusional, psychotic or ill in more than one area of daily living to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.

- The Covered Person's Mental Health Disorder must be treatable in an Inpatient facility.

- The Covered Person's Mental Health Disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the Covered Person's Mental Health Disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region.

- The attending Physician must be a psychiatrist. If the admitting Physician is not a psychiatrist, a psychiatrist must be attending to the Covered Person within 24 hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, Inpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial and prevocational modalities. Such programs must be a less restrictive alternative to Inpatient treatment.

Outpatient Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and

- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

- Must be provided by one of the following:

  - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided.
  - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
  - A state licensed psychologist.
  - A state licensed or certified Social Worker practicing within the scope of his or her license or certification.
  - Licensed Professional Counselor.
  - If outside of the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active treatment meeting the Clinical Eligibility for Coverage for the Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a Covered Benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.

- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:

  - Personality disorders; or
  - Sexual/gender identity disorders; or
  - Behavior and impulse control disorders; or
  - "V" codes (including marriage counseling).

- Services for biofeedback.

SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, Usual and Customary amount or the Negotiated Rate as applicable.

COVERED BENEFITS

Inpatient Services are payable subject to all of the following:

- The Hospital or facility must be accredited by The Joint Commission (formerly known as JCAHO), or other recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility for the treatment of substance abuse and chemical dependency. If outside of the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates and provides treatment for substance abuse and chemical dependency disorders. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- The Covered Person must have the ability to accept treatment.

- The Covered Person must be suicidal, homicidal, delusional or psychotic, or ill to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.

- The Covered Person's condition must be treatable in an Inpatient facility.

- The Covered Person's condition must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the Covered Person's condition must meet diagnostic criteria established and commonly recognized by the psychiatric community in that region.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such programs must be a less restrictive alternative to Inpatient treatment.

Outpatient Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and

- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

- Must be provided by one of the following:

  - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided.
  - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
  - A state licensed psychologist.

- A certified addiction counselor.
- A state licensed or certified social worker practicing within the scope of his or her license or certification.
- If outside of the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located, or a therapist with a Ph.D., or master's degree that denotes a specialty in psychiatry. The attending Physician, psychiatrist, or a counselor must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance abuse and chemical dependency disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE ABUSE EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

The Plan will not pay for:

- Treatment or care considered inappropriate or substandard as determined by the Plan.

- Inpatient charges for the period of time when full, active treatment meeting the Clinical Eligibility for Coverage for the Covered Person's condition is not being provided.

UTILIZATION MANAGEMENT
And Other Medical Management Services

Utilization Management is the process of evaluating whether services, supplies or treatment meet Clinical Eligibility for Coverage and are appropriate to help ensure cost-effective care. Utilization Management can determine Clinical Eligibility for coverage, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Notification requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Notification at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special Note: The Covered Person will not be penalized for failure to obtain Notification if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 48 hours of the next business day after receiving care or Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. The Notification requirement is not required for Hospital or Birthing Center stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Notification may be required for stays beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

DEFINITIONS

The following terms are used for the purpose of the Utilization Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Notified or Notification means a determination by the Utilization Review Organization on behalf of the Plan, with respect to whether a service, treatment, supply or facility is the most appropriate and cost-effective treatment for the care and treatment of an Illness or Injury and meets Clinical Eligibility for Coverage.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. Such assessment can be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING NOTIFICATION

Call the Utilization Management Organization **before** receiving services for the following:

- Inpatient stay in a Hospital or Extended Care Facility.
- Organ and tissue transplants.
- Durable Medical Equipment over $1,500 or any Durable Medical Equipment rentals over $500/month.

- Prosthetics over $1,000.
- All Inpatient stays and Day Treatment (Partial Hospitalization) for Mental Health Disorders, substance abuse and chemical dependency and residential treatment facility.
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.

Note that if a Covered Person receives Notification for one facility, but then the person is transferred to another facility, Notification is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

PENALTIES FOR NOT OBTAINING NOTIFICATION

A non-Notification penalty is the amount that must be paid by a Covered Person who does not call for Notification prior to receiving certain services. A penalty of 25% will be applied to applicable claims if a Covered Person receives services but did not obtain the required Notification for:

- Inpatient stay in a Hospital or Extended Care Facility.
- Organ and tissue transplants.
- Durable Medical Equipment over $1500 or any Durable Medical Equipment rentals over $500/month.
- Prosthetics over $1,000.
- All Inpatient stays and Day Treatment (Partial Hospitalization) for Mental Health Disorders, substance abuse and chemical dependency and residential treatment facility.
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.

The phone number to call for Notification is listed on the back of the Plan identification card.

Even though a Covered Person provides Notification to the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all of the provisions described in this SPD.

Medical Director Supervision. A UMR Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine medical appropriateness using evidence-based clinical criteria.

Case Management Referrals. During the Notification review process, cases are analyzed for a number of criteria used to trigger case to case management for review. These triggers include ICD-9 diagnosis codes, CPT codes and length-of-stay criteria, as well as specific criteria requested by the Plan Administrator. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

All Notification requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted by Plan Administrator request as long as the request is received within 30 days of the original determination. Retrospective reviews are performed according to our standard Notification policies and procedures.

Other Medical Management Services

Case Management Services are designed to identify catastrophic and complex Illnesses, transplants and trauma cases. UMR Care Management's case management specialists identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified from the Notification review process, national criteria and system flags based on ICD-9 diagnosis, CPT procedure code and potential high dollar claim criteria. UMR Care Management works directly with the patient, family members, treating Physician and facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person can request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine service is a 24/7 health information line that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred. When a Covered Person is enrolled as a Dependent by two different Employees, then this Plan will internally coordinate benefits.

The order of benefit determination rules below determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. The Secondary Plan will use the Covered Person's benefit reserve to pay up to 100% of the total allowable expenses Incurred during the remainder of the claim determination period.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

- Where an individual is covered under one plan as a Dependent and another plan as an Employee, member or subscriber, the plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.

- The plan that covers a person as a Dependent is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary. This rule does not apply if the rule in paragraph 3 (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
  - You are no longer actively employed by an employer; and
  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also have COBRA continuation coverage through the Plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
  - You or Your covered spouse have retiree coverage plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

This Plan is designed to cover You and Your Dependent(s) with health benefits. This Plan is not intended to serve as a supplement to, or replacement for, any payments or benefits You or Your Dependent(s) have or may recover when charges are Incurred as the result of an Accident, Illness, Injury or other medical condition caused by an act or omission of any Other Party. Benefits under this Plan are reduced or excluded subject to the terms and conditions of this Subrogation, Reimbursement and Offset Provision anytime there is an Other Party who is liable or responsible (legally or voluntarily) to make payments in relation to the Accident, Illness or Injury.

For purposes of this section, **Other Party** is defined to include, but is not limited to, the following:

- The party or parties that caused the Accident, Illness, Injury or other medical condition;
- The insurer or other indemnifier of the party or parties who caused the Accident, Illness, Injury or other medical condition;
- The Covered Person's own insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment, no-fault insurers or home-owner's insurance;
- A worker's compensation or school insurer;
- Any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the Accident, Illness, Injury or other medical condition.

For purposes of this section, **Recovery** is defined to include, but is not limited to, any amount paid or payable by an Other Party through a settlement, judgment, mediation, arbitration, or other means in connection with an Accident, Injury or Illness.

If the Covered Person and/or his or her Dependent(s) have the legal right to seek a Recovery from such Other Party, benefits will only be payable if You and Your Dependents agree to the following:

- That the Plan is subrogated to all rights the Covered Person may have, and You and Your Dependents acknowledge that the Plan will have a first priority lien and right of recovery, on any Recovery received from any Other Party as a result of an Accident, Illness, Injury or other medical condition caused by an act or omission of the Other Party. Any Covered Person accepting benefits from the Plan assigns from any such Recovery an amount equal to the benefits paid by the Plan. A Covered Person further agrees that notice of this assignment presented to the Covered Person's attorney and/or insurance company or Other Party responsible for payment of the damages is binding on the party receiving such notice.

- That the Covered Person, or their legal representative, shall notify the Plan of any claim or potential claim the Covered Person and/or their Dependent(s) have against any Other Party within 30 days of the act which gives rise to such claim. That, if requested, the Covered Person or his or her Dependent(s) or legal representative shall supply the Plan with any information that is reasonably necessary to protect the Plan's subrogation interests.

- If an act or omission of an Other Party causing an Accident, Illness or Injury results in payments being made under the Plan, that neither the Covered Person nor their Dependent(s) do anything that would prejudice the Plan's rights to recover payments.

- That, if requested, the Covered Person shall execute documents (including a lien agreement) and deliver instruments and papers and do whatever else is necessary to protect the Plan's rights. Such documents may require the Covered Person to direct their attorney (and other representatives) in writing to retain separately from any Recovery that the attorney or representative receive on the Covered Person's behalf an amount of money sufficient to reimburse the Plan as required by such agreement and to pay such money to the Plan. Failure or refusal to execute such documents or agreements or to furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full reimbursement. In the event the Covered Person does not sign or refuses to sign such an agreement, the Plan has no obligation to make any payment for any treatment required as a result of the act or omission of any Other Party, such agreement is expressly incorporated in this Plan and will be provided to the Covered Person at anytime upon request.

- The Plan is also granted a right of reimbursement from the proceeds of any Recovery obtained or that may be obtained by the Covered Person. This right of reimbursement runs concurrent with and is not necessarily exclusive of the Plan's subrogation and lien rights described above. A Covered Person shall promptly convey to the Plan any amounts received from any Recovery for the reasonable value of the medical benefits advanced by the Plan or provided by the Plan to the Covered Person.

- In the event that the Covered Person fails to cooperate with the Plan or fails to comply with the terms of this provision, the Plan may offset or otherwise reduce present or future benefits otherwise payable to the Covered Person or their Spouse or Dependent under the terms of the Plan. Moreover, in the event that a Covered Person fails to cooperate with the Plan, the Covered Person shall be responsible for any and all costs Incurred by the Plan in enforcing its rights, including but not limited to attorney's fees.

- That the Plan has a right to recover, through subrogation, reimbursement, offset or through any other available means, the following:

  - Any amount from the first dollar, that the Covered Person or any other person or organization on behalf of the Covered Person is entitled to receive as a result of the Accident, Illness, Injury or other medical condition, to the full extent of benefits paid or provided by the Plan; and
  - Any overpayments made directly to providers on behalf of the Covered Person for the Accident, Illness, Injury or other medical condition.

- That the Plan's rights under this section shall be in first priority, to the full extent of any and all benefits paid or payable under the Plan, and will not be reduced due to the Covered Person's own negligence or due to the Covered Person not being made whole.

- That the Covered Person shall be solely responsible for all expenses of recovery from any Other Party, including but not limited to all attorney's fees and costs, which amounts will not reduce the amount of reimbursement payable to the Plan under the operation of any common fund doctrines.

- That the Plan will not pay any fees or costs associated with any claim or lawsuit without the Plan's express written consent in advance.

- That the Covered Person or their legal representative or Legal Guardian, shall be considered a constructive trustee with respect to any Recovery received or that may be received from any Other Party in consideration of an Accident, Illness, Injury or other medical condition for which they have received benefits. Any such funds will be held in trust until the Plan's lien is satisfied.

- The Plan's rights apply to the Covered Person, to the spouse and Dependent(s) of a Covered Person, COBRA beneficiaries, and any other person who may recover on behalf of a participant, including the Covered Person's estate.

- That the Plan reserves the right to independently pursue and recover paid benefits.
- The Plan's Subrogation, Reimbursement and Offset provisions apply to a Recovery obtained by the Covered Person in connection with an Accident, Injury or Illness without regard to the description, name or label applied to the Recovery.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items are not considered Covered Benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions based upon the source of the Injury to treatment listed in the Covered Medical Benefits section when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Abortions:** Unless a Physician states in writing that:
   - The mother's life would be in danger if the fetus were to be carried to term, or
   - Abortion is medically indicated due to complications with the pregnancy.
   - The pregnancy is a result of rape or incest.

2. **Acts Of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

3. **Acupuncture Treatment.**

4. **Alternative / Complimentary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

5. **Appointments Missed:** An appointment the Covered Person did not attend.

6. **Aquatic Therapy.**

7. **Assistance With Activities of Daily Living.**

8. **Assistant Surgeon Services**, unless determined to meet the Clinical Eligibility for Coverage by the Plan.

9. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.

10. **Biofeedback Services**.

11. **Blood:** Blood donor expenses.

12. **Blood Pressure Cuffs / Monitors.**

13. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

14. **Chelation Therapy,** except in the treatment of conditions considered to meet the Clinical Eligibility for Coverage, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

15. **Claims** received later than 12 months from the date of service.

16. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a Covered Benefit.

17. **Counseling Services** in connection with financial or marriage counseling.

18. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

19. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.

20. **Custodial Care** as defined in the Glossary of Terms of this SPD.

21. **Custom-Molded Shoe Inserts,** including the exam for required Prescription and fitting.

22. **Dental Services:**

    - The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for x-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident.
    - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
    - Dental implants including preparation for implants.

23. **Developmental Delays:** Occupational, physical, and speech therapy services related to Developmental Delays, mental retardation or behavioral therapy that do not meet Clinical Eligibility for Coverage and are not considered by the Plan to be medical treatment. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

24. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.

25. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics or ostomy care.

26. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

27. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.

28. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.

29. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment.

30. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.

31. **Family Planning:** Consultation for family planning.

32. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

33. **Foot Care (Podiatry):** Routine foot care.

34. **Genetic Counseling** other than based on Clinical Eligibility for Coverage.

35. **Genetic Testing** other than based on Clinical Eligibility for Coverage.

36. **Hearing Services:** Implantable hearing devices.

37. **Home Births** and associated costs.

38. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

39. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

40. **Infertility Treatment:**

    - Diagnostic services.
    - Fertility tests.
    - Surgical reversal of a sterilized state which was a result of a previous surgery.
    - Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
    - Artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
    - Embryo transfer.
    - Freezing or storage of embryo, eggs, or semen.
    - Genetic testing.

    This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered person.

41. **Intoxication:** Injury that occurs while the Covered Person is driving under the influence of an intoxicant or has a blood alcohol level that would meet or exceed the definition of intoxication as set forth in the state where the Injury or Accident occurred. The Plan shall enforce this exclusion based upon available reasonable information.

42. **Lamaze Classes** or other child birth classes.

43. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

44. **Liposuction** regardless of purpose.

45. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

46. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this SPD.

47. **Massage Therapy.**

48. **Maternity Costs** for Covered Persons other than the Employee or spouse.

49. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

50. **Military:** A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.

51. **Nocturnal Enuresis Alarm** (Bed wetting).

52. **Non-Custom-Molded Shoe Inserts.**

53. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

54. **Not Determined to Meet the Clinical Eligibility for Coverage:** Services, supplies, treatment, facilities or equipment which the Plan determines do not meet the guidelines for Clinical Eligibility for Coverage. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.

55. **Nutritional Counseling** unless covered elsewhere in this SPD.

56. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Benefits.

57. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this SPD.

58. **Panniculectomy / Abdominoplasty** unless determined by the Plan to meet Clinical Eligibility for Coverage.

59. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

60. **Pharmacy Consultations.** Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like.

61. **Pre-Existing Conditions** exclusions, as specified in the Pre-Existing Conditions Exclusion section.

62. **Prescription Medication**, which is administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility and that require a Physician's Prescription.

63. **Private Duty Nursing Services** for Inpatient care.

64. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

65. **Return to Work / School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.

66. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.

67. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

68. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.

69. **Self-Inflicted** unless due to a medical condition (physical or mental) or domestic violence.

70. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

71. **Services** that should legally be provided by a school.

72. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.

73. **Sex Therapy.**

74. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.

75. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.

76. **Standby Surgeon Charges.**

77. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

78. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

79. **Telemedicine – Telephone or Internet Consultations.**

80. **Tobacco Addiction:** Services, treatment or supplies related to addiction to or dependency on nicotine.

81. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

82. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

83. **Vision Care** unless covered elsewhere in this SPD.

84. **Vitamins, Minerals and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections that are prescribed by a Physician and meet Clinical Eligibility for Coverage.

85. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

86. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.

87. **Weight Control:** Treatment, services or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness.

88. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.

89. **Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals whether, and under which circumstances, a procedure or service is generally a Covered Benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing notification as <u>required</u> by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan ***before*** obtaining the medical care such as in the case of notification of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for notification (See Pre-Determination above). Giving notification does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require notification for urgent or Emergency care claims, however Covered Persons may be required to notify the Plan following stabilization. Please refer to the Utilization Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if it could seriously jeopardize the person's life, health or ability to regain maximum function, or if, in the opinion of a Physician who has knowledge of the person's medical condition, would subject the person to severe pain that could not be adequately managed without the treatment or care being requested.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit a written letter to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. This letter must be signed by the Covered Person to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person/patient ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, auto accident, or other accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly follow the Plan's procedures for requesting notification, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for services that have been provided to a Covered Person, it will determine if the service is a Covered Benefit under this group health Plan. If it is not a Covered Benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a Covered Benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for Covered Benefits are paid according to an established fee schedule, a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Covered Expenses.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Usual And Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 90th percentile, see surgery and assistant surgeon under the Covered Benefits for exceptions related to multiple procedures. As it relates to charges made by a network provider, the term Usual and Customary means the Negotiated Rate as contractually agreed to by the provider and network (see above). A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.

- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

Determination Period On Hold: At the Plan's discretion, the time period that the Plan has to decide a claim may be put on hold ("tolled") when additional information is necessary from the Covered Person to process the claim. When claims information is missing, a notice requesting the necessary information may be sent to the Covered Person. The Covered Person then has 45 calendar days within which to provide the missing information.

If the Covered Person does not provide needed information to the Plan within 45 calendar days of the date on the notice, the Plan may make a decision on the claim based upon the information it has at that time, which may result in a denial or partial denial. The Covered Person will be fully responsible for payment of expenses not covered because of a denied or partially denied claim.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a Covered Benefit under this Plan.
- Services do not meet Clinical Eligibility for Coverage.
- Failure to comply with notification requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on not meeting Clinical Eligibility for Coverage or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- Covered Persons must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the EOB form five days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- Covered Persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.

- Covered Persons or their Personal Representative must submit a written request for a second review within 60 calendar days following the date received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal five days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no affect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Personal Representative) or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to:

This Plan contracts with various companies to administer different parts of this Plan. Covered Persons who want to appeal a decision or a claim determination that one of these companies made, should send appeals directly to the company that made the decision being appealed. The names and addresses of the companies that the Plan contracts include:

Send Medical appeals to
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pharmacy appeals to:
LDI INTEGRATED PHARMACY SERVICES

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines:

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. These actions will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. The Plan will pursue all appropriate legal remedies in the event of fraud.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee can choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken, and no new pre-existing requirements will be imposed. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (e.g., Your Physician, nurse, or midwife, or a physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- The Americans with Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Health Insurance Portability provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan shall Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will only Use and Disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Benefits Coordinator, Commander Administrative Services Division

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means Your employer.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, in the alternative, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person received the written amendment or termination letter from the Plan Administrator five days after the letter is mailed.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Customer should reflect the provisions of the Trust Agreement regarding distribution of assets upon termination of the Plan funded under the VEBA Trust:

The assets of the Arkansas State Policy Health Benefit Plan (Plan) upon termination of Plan shall be distributed to or placed into the successor plan for the benefit of the Covered Person's of the Plan. If no successor plan is established the Plan assets will be distributed pursuant to a resolution adopted by the Arkansas State Police Commission as pursuant to Arkansas Code §2-8-10 (c).

If no resolution is adopted by the Arkansas State Police Commission, the assets will be distributed by the General Assembly of the State of Arkansas.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Accredited Institution of Higher Education means, for the purposes of this Plan, a two-year or four-year degree-granting college or university or licensed trade school and which is accredited in the current publication of Accredited Institutions of Higher Education.

Activities of Daily Living (ADL) means the following, with or without assistance: Bathing, dressing, toileting and associated personal hygiene; transferring (which is to move in and out of a bed, chair, wheelchair, tub or shower); mobility, eating (which is getting nourishment into the body by any means other than intravenous), and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or for treating condition of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation or when deemed to meet Clinical Eligibility for Coverage, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well being of You or Your Dependent.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency including the following: ambulance, anesthesiology, assistant surgeon, pathology and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

Certificate of Creditable Coverage means a certificate or other documentation that is provided to a person upon losing health care coverage. The certificate or other documentation specifies how much Creditable Coverage a person has and is used to reduce the length of a Pre-Existing Condition exclusion period under a Plan.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a step Child; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or Spouse's permanent or temporary Legal Guardianship; a grandchild in the permanent custody of the Employee, provided they reside in the participant's household and the participant is acting as a parent, or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Clinical Eligibility for Coverage – Refer to Covered Benefits below.

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, Children, step Children and grandchildren.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Co-pay is the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Benefit or **Clinical Eligibility for Coverage** means treatment, services, supplies, medicines or facilities necessary and appropriate for the diagnosis, care or treatment of an Illness or Injury and that meet Clinical Eligibility for Coverage as determined by the Plan. Covered Benefits do not include those listed under the Exclusions section but include services, supplies, medicines or facilities that are:

- Generally provided in accordance with accepted medical practice and professionally recognized standards; and
- Provided safely at the appropriate level of care or services; and
- Not provided solely for the convenience of the Covered Person, his or her family, or any provider; and
- Known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence, then by professional standards, and finally by expert opinions; and
- Cost-effective for the condition, compared to alternative interventions, including no intervention. Cost-effective does not necessarily mean the lowest price.

In determining Covered Benefits, consideration is given to the customary practice of providers in the community or field of specialty. However, the fact that a provider may prescribe, order, recommend or approve a service, supply, medicine or facility does not, of itself, make the service a Covered Benefit.

Covered Expenses means any expense, or portion thereof, which is Incurred as a result of receiving a Covered Benefit under this Plan.

Covered Person means an Employee, Retiree or Dependent who is enrolled under this Plan.

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Delays are characterized by impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Delays may not always have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental Illness or other neurological symptoms or Illness.

Durable Medical Equipment means equipment which meets all of the following criteria:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose with respect to an Illness or Injury.
- Generally is not useful to a person in the absence of an Illness or Injury.
- Is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined in the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins.
- For anyone who enrolls for Late Enrollees, the Enrollment Date is the first day coverage begins.

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology\ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and therapies deemed to meet Clinical Eligibility for Coverage for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Full-Time Student or Student means a Student attending high school or an Accredited Institution of Higher Education. To be considered Full-Time Students, Dependents must attend at least 12 credits per semester or 6 credits per semester for graduate studies, or equivalent if the school operates on an alternative term basis. Alternatively, the Student must meet the accredited college or university's definition of Full-Time Student. Students attending a combination of accredited institutions and whose total combined attendance meets the requirements listed in this paragraph also will qualify as Full-Time Students. With respect to a licensed trade school, attendance requires enrollment in a 6 month or longer training program for at least 20 hours per week that awards a formal certificate upon graduation and the school must be accredited by a national governing body.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician which is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician; physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means:

- A facility that is licensed as an acute Hospital; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons as Inpatients at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- It is accredited by The Joint Commission (formerly known as JCAHO), or is recognized by the American Hospital Association (AHA) and is Qualified to receive payments under the Medicare program, or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Always provides 24 hour nursing services by registered graduate nurses; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term "Illness" when used in connection with a newborn Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date the service or treatment is given, the supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means someone who signs an agreement with the employer as and Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with Section § 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at the Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: Basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation and mathematical reasoning. Specific learning disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling and level of intelligence.

Legal Guardianship/Guardian means the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Lifetime Maximum Benefit means the maximum amount of Covered Benefits payable while a person is covered under this Plan. When the Lifetime Maximum Benefit is met, a Covered Person is no longer eligible for benefits under this Plan. Lifetime does not mean during the lifetime of the Covered Person.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Mental Health Disorder means disorders that are clinically significant psychological syndromes associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness or death.

Multiple Surgical Procedures means when more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventative maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means ARKANSAS STATE POLICE HEALTH BENEFIT PLAN Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within the timeframe specified in the Pre-Existing Condition Provision section of this document.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug, that could be a medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury.

Primary Care Physician means a family practitioner, general practitioner, non-specializing internist (i.e., those that work out of a family practice clinic), pediatrician, physician assistant, nurse practitioner or registered nurse practitioner. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners give routine medical care; internist treat routine and complex conditions in adults; and pediatricians treat Children.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered or certified by the state in which the provider practices.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic when a physical impairment exists and the surgery restores or improves function.

Retired Employee (Retiree) means a person who was employed full time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

Significant Break in Coverage means a period of 63 consecutive days during which a person does not have any Creditable Coverage.

Specialist means a provider who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Providers that are not considered a Specialist include, but are not limited to, family practitioners, non-specializing internists, pediatricians, physician assistant, nurse practitioner or registered nurse practictioner.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- Provides drug services as needed for medical operations and procedures performed;
- Provides for the physical and emotional well being of the patients;
- Provides Emergency services;
- Has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

Temporomandibular Joint Disorder (TMJ) shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) is a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Disease – Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:

    - Personality disorders; or
    - Sexual/gender identity disorders; or
    - Behavior and impulse control disorders; or
    - "V" codes.

Urgent Care is the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have an Injury or Illness that requires immediate care but is not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

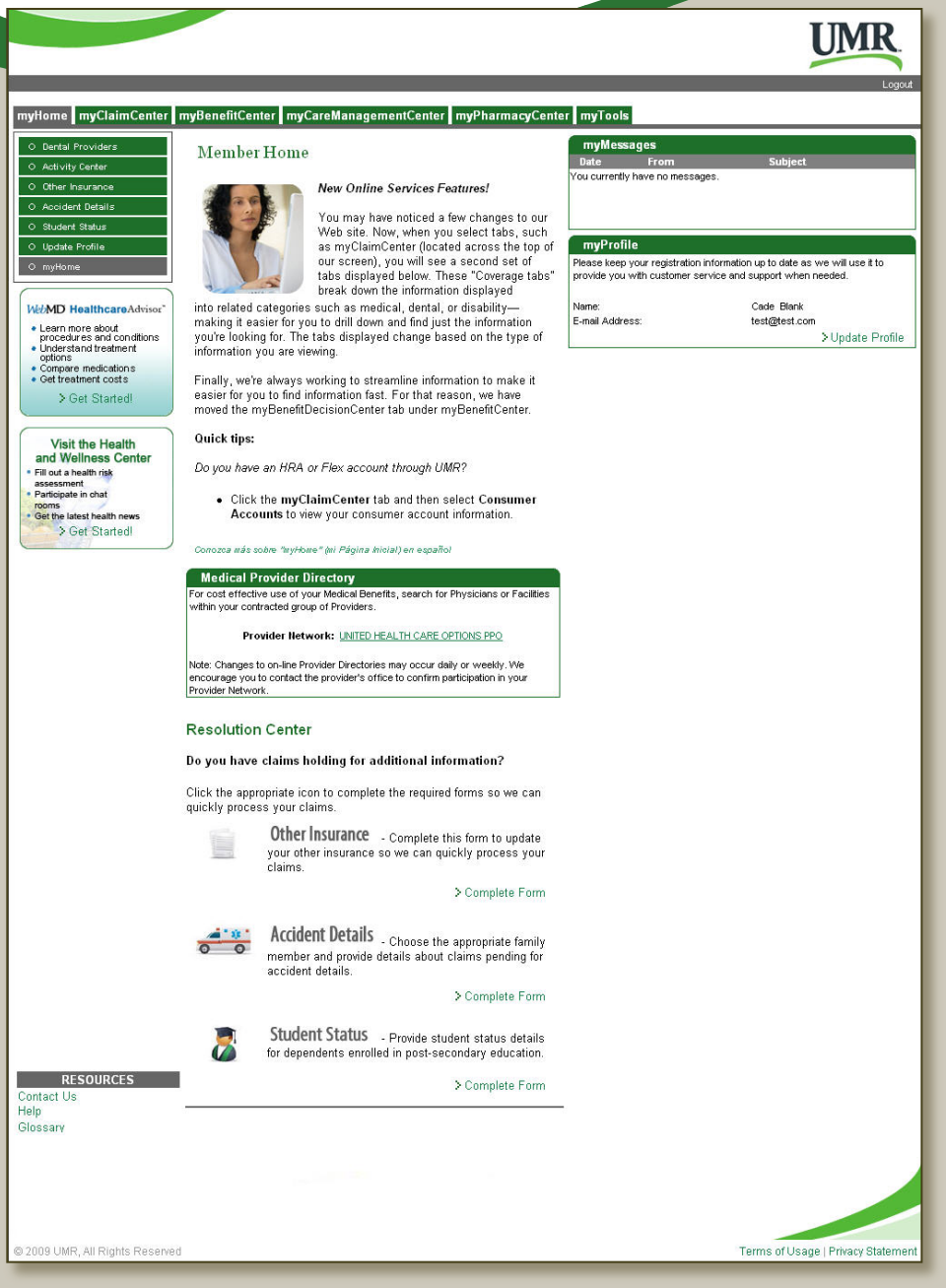
Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

You, Your means the Employee.

UMR Online Services

Get Instant Access to All Your Claim and Benefits Information

To get started, visit ***www.umr.com.***



UMR online services give you the information you need, when you need it. Here are just a few of the many services you'll find on our Web site:

- Displays up to five recent claims with access to all claims.
- Lists the providers in your network.
- Gives you information about other insurance, accident details and student status.
- Summarizes claim history for all members.
- Shows current deductibles and out-of-pocket payments if applicable.
- Provides your current coverages.
- Keeps you informed about important benefit and Web news.
- Gives you access to all applicable claim forms.
- Provides Explanation of Benefits (EOB) details.

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Important Notice from the Arkansas State Police About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Arkansas State Police and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **The Arkansas State Police has determined that the prescription drug coverage offered by the Arkansas State Police Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you do decide to enroll in a Medicare prescription drug plan and drop your **Arkansas State Police** prescription drug coverage, be aware that you and your dependents **may or may not** be able to get this coverage back.

Please contact your Plan Administrator for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **Arkansas State Police** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium

may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about Your Current Prescription Drug Coverage…
Contact Bennie Adams of the **Arkansas State Police** at 501-618-8720. For a further explanation of the prescription drug coverage plan provisions/options under the **Arkansas State Police Health Plan** please consult the relevant plan document provisions.

For More Information About This Notice…
The Arkansas State Police has engaged the services of Part D Advisors, Inc. to provide you with further information about this notice. Part D Advisors, Inc. can be reached, toll free, at (888) 447-2783. NOTE: You will receive this notice each year. You will also get it before the next period you can enroll in a Medicare prescription drug coverage, and if this coverage through Arkansas State Police changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	November 1, 2010
Name of Entity/Sender:	**Arkansas State Police**
Contact--Position/Office:	Human Resources, Arkansas State Police
Address:	#1 State Police Plaza Drive, Little Rock, Ar 72209
	Phone Number: (501) 618-8720

ARKANSAS STATE POLICE HEALTH BENEFIT PLAN

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan

ARKANSAS STATE POLICE MEDICAL BENEFIT PLAN

NOTICE OF GRANDFATHERED STATUS

UNDER THE

PATIENT PROTECTION AND AFFORDABLE CARE ACT

NOVEMBER 1, 2010

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Arkansas State Police, 1 State Police Plaza Drive, Little Rock, AR 72209. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Notice of Privacy Practices

From Arkansas State Police Health Benefit Plan

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

Arkansas State Police (ASP) is responsible for managing the administration for the Arkansas State Police Health Benefit Plan. As a group health plan, ASP is required by law to maintain the privacy of protected health information. The Notice of Privacy Practices describes the types of information, its uses and disclosures and your rights regarding that information.

"Protected health information" (PHI), means information that is individually identifiable and is protected by privacy regulations. Examples include information regarding the health care treatment, payment, or operations that can identify you or your dependents. This information is obtained from enrollment forms for health care coverage, surveys, healthcare claims, specialist referrals, your medical records, and other sources. You might provide protected health information by telephone, fax, letter, or e-mail. Other sources of protected health information include, but are not limited to, healthcare providers, such as insurance administrators, network providers, claims processors (hereafter referred to as business partners or affiliates). When used with health related information, any of the following would be considered protected health information:

- Marital status
- Gender
- Name, address, and date of birth
- Social Security Number
- Information regarding dependents
- Other similar information that relates to past, present or future medical care

Disclosures of protected health information not requiring authorization

The law allows the use and disclosure of protected health information (with the exception of genetic information) without the authorization of the individual for the purpose of treatment, payment, and/or health care operations, which includes, but is not limited to:

- Treatment of a health condition
- Payment for treatment
- Business planning and development
- Claims administration
- Coordination of benefits
- Insurance underwriting
- Enrollment into the group health plan
- Premium billing
- Eligibility for coverage issues
- Payment of claims
- Complaint review
- Appeals review
- Regulatory review and legal compliance
- Case Management
- Fraud abuse detection or compliance
- Utilization Review

Uses and disclosures for treatment: Your protected health information will be obtained from or disclosed to health care providers involved in your or your dependents treatment.

Uses and disclosures for payment: Your protected health information will be obtained from and disclosed to individuals involved in your treatment for purposes of payment. Your protected health information may be shared with persons involved in utilization review, or other claims processing.

Uses and disclosures for health care operations: Your protected health information will be used and disclosed for plan operations including but not limited to underwriting, premium rating, auditing, and business planning. In order to ensure

the privacy of your protected health information, ASP has developed privacy policies and procedures. During the normal course of business, ASP may share this information with its business partners or affiliates that have signed a contract specifying their compliance with ASP's privacy policies.

NOTE: Only the minimum necessary amount of information to complete the tasks listed above will be disclosed. Disclosures of personal health information requiring authorization in situations, other than outlined above, ASP will ask for your authorization to use or disclose your protected heath information. ASP will use or disclose information in these circumstances pursuant to the specific purpose contained in your authorization.

• Usually, only the person to whom the protected health information pertains may make authorization.
• In some circumstances, authorization may be obtained from a person representing your interests (such as in the case where you may be incapacitated and unable to make an informed authorization) or in emergency situations where authorization would be impractical to obtain.
• Any 3rd party acting as your advocate (for example, a family member, your employer, or your elected official) would require an authorization.

Forms
Forms may be obtained from ASP, Forms are:
• Authorization for Release of Protected Health Information
• Revoking Authorization for Release of Protected Health Information

Your Rights
• You have the right to review and copy your protected health information maintained by ASP. If you require a copy of PHI, the first request will be provided to you at no cost. A reasonable fee will be charged for shipping additional or subsequent copies.
• You can request a copy of the Notice of Privacy Practices from ASP.
• You have the right to request an accounting, or list, of non-routine disclosures of your protected health information by ASP as of the compliance date. This request must be made in writing.
• You have the right to request a restriction on the protected health information that may be used and/or disclosed. You have the right to request that communication regarding your protected health information from ASP be made at a certain time or location. This request must be in writing and ASP reserves the right to refuse the restriction.
• You have the right to receive confidential communication of PHI at alternate locations and by alternate means.

If you believe your privacy rights have been violated, you have the right to register a complaint with ASP's Privacy Office:

ASP Privacy Officer
#1 Arkansas State Police Plaza Dr.
Little Rock, AR 72209
Phone: (501) 681-8701
Fax: (501) 681-8739

Or you can send your complaint to the Office for Civil Rights:

Office for Civil Rights, U.S. Department of Health and Human Services
1301 Young Street – Suite 1169
Dallas, TX 75202
Phone: (214) 767-4056
TDD: (214) 767-8940
Fax: (214) 767-0432

To email the Office for Civil Rights, send your message to : OCRCompliant@hhs.gov. Under the HIPAA regulations and guidelines, there can be no retaliation for filing a complaint.

Changes to Privacy Practices

If ASP changes its privacy policies and procedures, an updated Notice of Privacy Practices will be provided to you. This notice became effective on November 1, 2010.

Notice to Enrollees in a Self-funded Non-federal Government Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Arkansas State Police has elected to exempt Arkansas State Police Health Benefit Plan from the following requirements:

1. Limitations on pre-existing condition exclusion periods.

2. Special Enrollment Periods.

3. Prohibitions against discriminating against individual participants and beneficiaries based on health status.

4. Standards relating to benefits for mothers and newborns.

The exemption from these Federal requirements will be in effect for the Plan Year beginning January 1, 2011 and ending December 31, 2011. The election may be renewed for subsequent plan years.

The Plan does provide the following benefits that are similar to the requirements set forth above:

1. Limitations on pre-existing condition exclusion periods. Under the Plan a preexisting condition means a condition or illness which existed within a 12 month period prior to the covered person's effective date.

2. Special Enrollment Rights. The Plan does provide for late enrollments. However, individuals must submit evidence of good health and be accepted into the plan.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

ARKANSAS STATE POLICE HEALTH BENEFIT PLAN

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (WHCRA)

The Arkansas State Police Health Benefit Plan is required by law to provide you with the following notice. This does not represent a change in your coverage. The Women's Health and Cancer Rights Act of 1998 (WHCRA) includes important protections for patients who elect breast reconstruction in connection with mastectomy.

For a participant who receives benefits in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits for the above services will be subject to the same cost-sharing provisions (i.e., deductible, copayment and coinsurance) as may be deemed appropriate and as are consistent with those established for other covered services. Your plan is already in compliance with this mandate and provides coverage for this benefit.

ARKANSAS STATE POLICE HEALTH BENEFIT PLAN

NOTICE OF ENROLLMENT OPPORTUNITES UNDER

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

November 1, 2010

LIFETIME LIMIT

The lifetime limit on the dollar value of benefits under the Arkansas State Police Health Benefit Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. Effective date of coverage will be January 1, 2011. For more information contact the Plan Administrator at:

Arkansas State Police
1 State Police Plaza Drive
Little Rock, AR 72209
(501) 618-8720

EXTENSION OF DEPENDENT COVERAGE TO AGE 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Arkansas State Police Health Benefit Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective January 1, 2011. For more information contact the Plan Administrator at:

Arkansas State Police
1 State Police Plaza Drive
Little Rock, AR 72209
(501) 618-8720

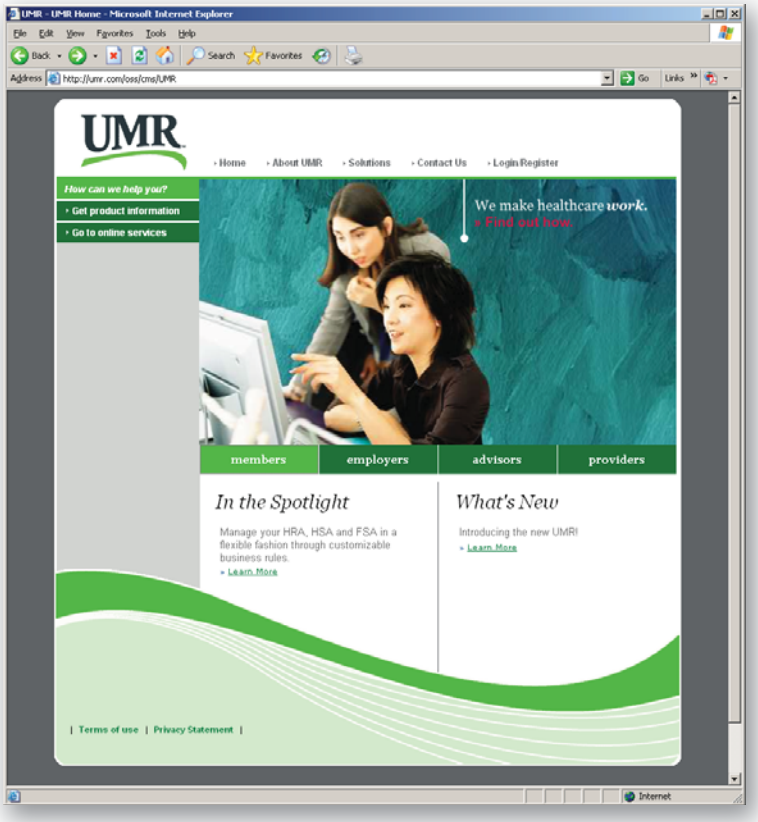
Online Services from UMR

Accessing Online Services

1. Visit: **www.umr.com**
2. Select "Members"
3. **For members with health or dental coverage:** Enter the member ID located on your ID card in the Online Services Access box.
4. Click "Go to my online services." Our Web site will redirect you to your online services home page.
5. If you have previously registered for online services, enter your username and password in the member login box and click "Submit" to login, or

   If you have not yet registered for online services, click the "Need a Username? Register here." link and follow the prompts to complete your registration.

That's all you need to do. You now have access to a variety of services, including everything that follows.



Claim, Eligibility and Benefit Inquiry

You can view your claims (including copies of EOBs), eligibility and benefit information any time of the day or night. In addition, you can view the status of medical deductibles, out-of-pocket and lifetime maximum amounts. You can also access a summary of claim dollars for current year-to-date and prior year claim charges.

Other Insurance and Accident Details

If you have claims pending for updates to other insurance or accident details information, you can make those updates online. Any claims pending will be automatically reprocessed.

(contined on back)

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ID Card Ordering

Order duplicate or replacement ID cards quickly and easily.

Member Health Information

UMR provides a wealth of information and services to help you live a healthier life. Tools, such as Healthcare Advisor, can help you make the best decisions about health conditions and prescription drugs.
In addition, we provide links to excellent health information sites, articles and a whole lot more.

Provider Network Links

For your convenience, we've set up a link to your provider network. When you click on the link, the network provider's home page is displayed. You can click the link on the home page to search for in-network physicians or medical facilities.

UMR provides a wealth of information and services to help you live a healthier life.

Forms

Our most widely used forms are available online for easy access.

Questions?

If you have any questions or problems, please contact our technical support team at 1-866-922-8266 or reference our online tutorial guides.

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